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**Perceived leadership style, style flexibility, and style effectiveness  
of government hospital administrators in Thailand**

Chuwattanakul, Pongsin, Ph.D.

Andrews University, 1993

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Andrews University

School of Education

PERCEIVED LEADERSHIP STYLE, STYLE FLEXIBILITY,  
AND STYLE EFFECTIVENESS OF GOVERNMENT  
HOSPITAL ADMINISTRATORS IN THAILAND

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Pongsin Chuwattanakul

August 1993

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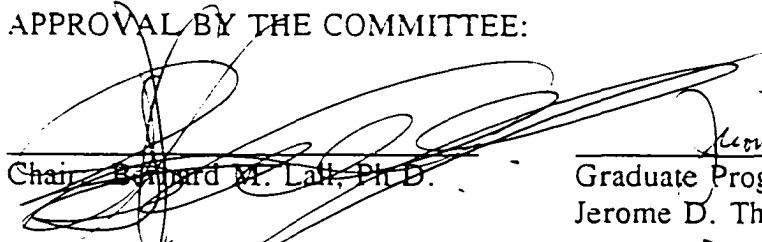
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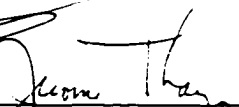
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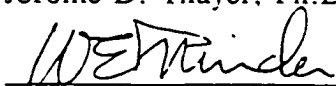
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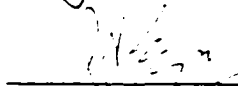
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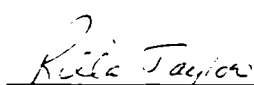
  
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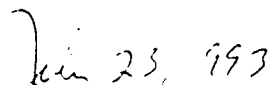
  
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External: Rilla Taylor, Ph.D.

  
Date approved

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ABSTRACT

PERCEIVED LEADERSHIP STYLE, STYLE FLEXIBILITY,  
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HOSPITAL ADMINISTRATORS IN THAILAND

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## ABSTRACT OF GRADUATE STUDENT RESEARCH

### Dissertation

Andrews University

School of Education

Title: PERCEIVED LEADERSHIP STYLE, STYLE FLEXIBILITY,  
AND STYLE EFFECTIVENESS OF GOVERNMENT HOSPITAL  
ADMINISTRATORS IN THAILAND

Name of researcher: Pongsin Chuwattanakul

Name and degree of faculty chair: Bernard M. Lall, Ph.D.

Date completed: August 1993

### Problem

Many health care organizations have a great need for leaders who can handle the complex mix of health care facilities, legal and patient demands. Currently, hospital administrators of government-operated hospitals in Thailand are selected from physicians. These physicians are not directly trained to be professional hospital administrators. It was the purpose of this study to study and reveal their leadership styles.

## Method

A descriptive design was used to study the leadership styles, style flexibility, and style effectiveness of hospital administrators in self-reports and as perceived by supervisors. The LBA II-Self (Leader Behavior Analysis II: Self Perceptions of Leadership Style) and the LBA II-Others (Leader Behavior Analysis II: Others' Perceptions of Leadership Style) instruments and a demographic information questionnaire were used for data collection.

For the purpose of this study, the supervisors' perception was used as others' perception to define the leadership style of hospital administrators. The term "supervisor" refers to the Provincial Chief Medical Officer (PCMO) (*see Appendix E & Definition of terms*).

## Results

Major conclusions drawn as a result of information and experience gained during the course of the study were:

1. The hospital administrators of government-operated general hospitals in Thailand used supportive behavior more often than directive behavior. Both the hospital administrators and their supervisors perceived that the administrators were highly supportive leaders.
2. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of flexibility in

utilizing their leadership styles. The administrators saw themselves as more flexible in utilizing different leadership styles than their supervisors did.

3. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of effectiveness in the use of their leadership styles.

4. The factors of age, educational background, and years of working experience in current position were unrelated to the leadership styles, leadership style flexibility, and leadership style effectiveness as perceived by the hospital administrators and by their supervisors.

### **Conclusions**

Based on this study, the "supporting" style (S3) was the predominant leadership style of the hospital administrators. The factors of age, educational background, and years of working experience in current position were unrelated to the leadership styles, leadership style flexibility, and leadership style effectiveness as perceived by the hospital administrators and by their supervisors. However, it was concluded that more leadership studies are needed because this result shows the inconsistencies to some previous studies (*see Review of literature*).

The following recommendations are presented for consideration:

1. The subordinates' perception be used to study leaders' leadership styles as compared to leaders' self perception

2. Further study be done on the strength of each primary leadership styles
3. Qualitative research be conducted to reveal the possible factors that might relate to the leadership styles, style flexibility, and style effectiveness of hospital administrators in Thailand
4. The study be replicated to study leaders in other organizations in Thailand, such as leaders in other government-operated institutions, leaders in private hospitals, and managers in business organizations to determine whether similar results are obtained
5. Training programs in leadership styles be made available to help hospital administrators become sensitive to style flexibility and more aware of the appropriateness of the styles they use
6. Further experimental research be conducted to determine whether hospital administrators with training in Situational Leadership II theory are significantly different in utilizing their leadership styles, style flexibility, and style effectiveness from those without such training.

## CHAPTER I

### INTRODUCTION

Any organization today, whether it is a large multi-national corporation, a non-profit organization, or a start-up entrepreneurial company, requires strong, positive leadership to compete successfully (Jeffries, 1992). Over the decades scholars have attempted to identify leadership styles that are most effective in attaining goals, motivating followers, or satisfying followers. Management trainers use the concept of style to help organizational leaders identify more successful ways of interacting with followers (Zorn & Violanti, 1993). Researchers have devoted much time to the study of leadership in order to understand and improve organizations, but none has been able to describe it in comprehensible terms, nor has been able to generate an understanding of leadership that is both intellectually compelling and emotionally satisfying. The concept of leadership remains largely inexplicable and enigmatic (Bass, 1990; Meindl, Ehrlich, & Dukerich, 1985; Zorn & Violanti, 1993).



Robert (1991) criticized that leadership is an elusive term which has different meanings to different people. Although the concept of leadership style has come under criticism (Rost, 1991; Smith & Peterson, 1988), it is still widely used in research and management training and development (Zorn & Violanti, 1993).

Although all professions claim the need for administrative leadership, hospital administration is perhaps the most needy when one considers the limited number of hospital administrators prepared with appropriate degrees (Eubanks, 1990). Those who administer hospitals, the formal leaders, have considerable influence in resolving problems. Hospital administrators, because of their leadership position, should have the competence to determine and utilize effective leadership skills (Eubanks, 1990; Weil, 1984).

Griest and Belles (1990) noted that according to the survey conducted by the Management Psychology Group, the majority of health care administrators surveyed apparently saw themselves as lacking some dynamic leadership qualities that could make them more effective. They also cited that health care administrators may need to work on developing their leadership- and people- management skills before seeking further training in the technical aspects of their jobs.

In Thailand, the leadership concepts such as Theory X and Theory Y of McGregor, Theory Z of Ouchi, and Situational Leadership Theory of

Hersey and Blanchard are recognized, taught, and practiced in college level. The Thai government implements these conceptual frameworks in its national health development plan in order to develop government officials' leadership and management skills (Health Education Division and Health Planning Division, 1991). However, in contrast to the Western countries where most of the hospital directors are appointed from those who are holding a Master of Health Administration or a Master of Business Administration degrees, current government hospital administrators in Thailand are chosen from physicians. Most are male. These physicians have worked their way up through operational ranks to their administrative positions. These physicians are not directly trained to be professional hospital administrators. Nevertheless, they are exercising leadership and taking responsibility for the operational and functional structures of hospital services in Thailand (Thai National Health Care Association, 1991).

Considerable data exist concerning the leadership styles of general business administrators, but very little is known about hospital administrators, especially in Thailand. A search of dissertation Abstract from the year 1861 to 1991 found no research to reveal the leadership styles of hospital administrators in Thailand (University Microfilms, 1992). This indicates the need for more research on this area of leadership.

Zorn and Violanti (1993) identified that the study of leadership styles relates to organizational effectiveness, goal accomplishment, and productivity. Jeffries (1992) added that lacking formal training in administration is one of many reasons which causes decline in organizational productivity. In order to understand and improve health care productivity and systems to meet the needs of society in Thailand, the hospital administrators' leadership styles must be studied and strengthened. Thus, this research was aimed at studying the leadership styles of hospital administrators of the government-operated hospitals in Thailand.

The Situational Leadership II theory developed by K. Blanchard, P. Zigarmi, and D. Zigarmi (1985) was the basis of the framework of this dissertation. Blanchard et al. (1985) stated: "Self-perception of how the leader behaves is interesting but it tells the leader only how he/she intend to act. Unless it matches the perceptions of others it is not very helpful" (p. 20). In order to illustrate the above thought it should be mentioned that Hersey and Blanchard (1988) defined leadership style as follows:

The leadership style of an individual is the behavior pattern that a person exhibits when attempting to influence the activities of others as perceived by those others. This may be very different from the leader's perception, which we shall define as self-perception rather than style. (p. 116)

For the purpose of this study, the supervisors' perception was used as others' perception to define the leadership style of hospital administrators.

The term "supervisor" refers to the Provincial Chief Medical Officer (PCMO) (*see Appendix E and Definition of terms*).

### **Statement of the Problem**

Today, government hospitals have expanded greatly in Thailand. Changes have occurred primarily as a consequence of several factors: (1) a lack of appropriate planning regarding financial support; (2) inadequate physical settings; (3) implementing new policies ordered by the new National Health Plan; (4) new services resulting from the demands and needs claimed by patients, staff, and employees; and (5) an accelerated process of patient enrollment. Other external factors, such as societal influences, government changes, and the increased movement to privatize public hospital, are related. Government hospital administrators are dealing with the above mentioned factors in a very direct way. Many health care organizations have a great need for leaders who can handle the problems mentioned above including the complex mix of health care facilities, and legal and patient demands. There is a need for well-prepared leadership to begin to envision the development of the organization, to strengthen values, and to recognize the struggles of the system and the people (Allen, 1991).

However, government hospital administrators in Thailand are selected from the physicians who are trained to be physicians, not professional

hospital administrators. These hospital administrators are perceived to have insufficient credibility, training, and managerial skills as professional hospital administrators. The problem of this study was to determine these government hospital administrators' leadership styles, style flexibility, and style effectiveness. To date, no study related to the leadership style of government hospital administrators has been conducted in Thailand. This study was the first attempt to survey a sample that will be drawn from government hospital administrators to determine their leadership styles.

### **Purpose of the Study**

The purpose of the study was to investigate and identify the leadership styles (as defined by the Leader Behavior Analysis II instrument) (*see Appendix A & B*) of the government hospital administrators in Thailand and to examine what relationships they had with selected demographic variables-- age, educational background, and years of experience in current position. This study also examined the following questions:

1. What is the primary self-perceived leadership style of Thai government hospital administrators?
2. What is the primary leadership style of Thai government hospital administrators as perceived by the supervisors?

3. What is the relationship between self-perceived leadership styles, leadership flexibility, and leadership effectiveness; and supervisor-perceived primary leadership style, leadership flexibility, and leadership effectiveness of the Thai government hospital administrators?

4. What is the relationship between the primary leadership style, leadership flexibility, and leadership effectiveness of the government hospital administrators in Thailand and age, educational background, and years of experience in current position?

### **Significance of the Study**

The significance of the study is as follows:

1. A study of the leadership styles of Thai government hospital administrators may help hospital administrators to acquire awareness in their own leadership styles as a step toward becoming effective health care leaders.

2. This study was conducted in the hope that it might help furnish information that would be of value to personnel who are responsible for improving hospital administrators' effectiveness.

3. Since professional role socialization occurs in the practice setting as well as the educational setting, the hospital leader can be a significant role model (Griest & Belles, 1990). Knowledge of the perceptions and activities

of the hospital administrator in a health care setting is needed so that the socialization process, both taught and modeled, can be internalized in the emergent practitioner and leadership group (Griest & Belles, 1990; Johnson, 1984; Weil, 1984).

4. The hospital administrator is a role model for his/her staff, exemplifying the standards of professional practice and effective leadership style to attain both organizational goals and patient-care needs (Allen, 1991; Eubanks, 1990; Weil, 1984). Knowing the hospital administrators' leadership styles helps give direction to both the administrators and the followers in how to work and communicate with each other more effectively.

5. This study may provide information that would be of value to educators who are responsible for health administrators in the following areas: (a) the development or alteration of selected strategies for hospital administrators; (b) the development or alteration of training programs for hospital administrators; and (c) the development of in-service programs for hospital administrators.

6. This study uses the Leader Behavior Analysis II instrument which consists of LBA II-Self and LBA II-Other developed by Blanchard, Hambleton, Forsyth, and Zigarmi (1991a,b,c) as instruments. This study brings new knowledge to the area of leadership research and also provides a data base for future research.

In addition, findings of this study may indicate the existence of differences in leadership styles that have been used in specific situations. Findings might result in better methods for future decision-making processes of this governing body. This investigation would call attention to the ways that this administrative structure has operated up to now. By having a better understanding of the leadership style patterns of the government, hospital administrators could derive great benefit.

### **Theoretical Framework**

Over 3,000 studies have been conducted during the past 70 years in the area of leadership, and dozens of theories and models have been proposed (Hersey & Stinson, 1980). Major reviews of literature in leadership appear in both Bass (1990) and Jensen (1981). Leadership studies utilize a variety of conceptual frameworks to examine leadership. An enduring interest, however, is the patterns of traits, behaviors, or styles exhibited by those in leadership positions or by those who are successful in providing leadership (Zorn & Violanti, 1993).

The Situational Leadership II theory developed by K. Blanchard, P. Zigarmi, and D. Zigarmi (1985) is one of the most-recognized leadership theories designed to assess leadership style. The Situational Leadership II model was the basis of the framework of this dissertation. This model



allows for the description of the perceived leadership styles of the hospital administrators of all government-operated general hospitals in Thailand.

The Situational Leadership II theory and its model grow out of Situational Leadership theory (Hersey & Blanchard, 1969, 1988). According to Situational Leadership theory, no one leadership style is suited for all people in all situations. Successful leaders are those who can adapt their styles to fit the maturity level of the people the leader is attempting to influence (Hersey & Blanchard, 1969, 1977, 1982, 1988). Situational Leadership theory attempts to use the maturity or development level,—defined as ability plus willingness,—of the follower as a moderator variable on the leader's use of task and relationship behavior. Maturity or development level is a function of the follower's task-related skills, knowledge of the task, abilities, self-confidence, willingness to complete the task, and motivation. The follower's maturity or development level determines the type of behavior he/she needs from the leader. For example, a new person on the job has a maturity or development level of 1 and needs "directing" leadership behavior; that is, the follower needs to be given instructions to complete the task, with little emphasis on the relationship. As the follower matures or becomes more developed, he/she needs differing amounts of task and relationship behavior from the leader (Zorn & Violanti, 1993).

The leadership styles involved in the Situational Leadership II model are divided into four quadrants and are the products of the combination of task and relationship behavior: (1) directing, (2) coaching, (3) supporting, and (4) delegating. These four styles consist of different combinations of two basic leadership behaviors that the leader can use when trying to influence someone else: Directive Behavior and Supportive Behavior (Blanchard et al., 1985). Directive behavior is the extent to which the leader engages in one-way communication; spells out the follower(s') role and tells the follower(s) what to do, where to do it, when to do it and how to do it; and then closely supervises performance. Supportive behavior is the extent to which the leader engages in two-way communication, listens, provides support and encouragement, facilitates interaction and involves the follower(s) in decision making (Zigarmi, Edeburn, & Blanchard, 1991).

Different positions regarding this model have been adopted by researchers in the area of leadership. Yukl (1989) recognized that the model presents some deficiencies; but the model has provided positive contributions, such as flexible and adaptative leadership behavior, leadership awareness of building skills and confidence in followers, and "the recognition that the leader behavior can be exhibited in a more or less skillful fashion" (p. 108). Vroom (1984) described the model as useful in leader training rather than in selection and job engineering. Hersey and

Blanchard (1988), after conducting various studies on situational leadership, claimed that this model enables a leader to learn about his/her behavior in the leader's own environment and how that behavior is perceived by others. Zorn and Violanti (1993) described Situational Leadership theory as one of the most useful instructional tools that the researcher has produced to help assess to the knowledge of leadership styles.

The Situational Leadership II model has been used worldwide, including Thailand. The public and private sectors have been training managers and executives using this model. In general, the model seems to be appropriate for use in this study in which the main scenario involves Thai government-operated general hospitals. In this study, some demographic variables were investigated as compared to leadership styles. The literature findings showed similarities and discrepancies in variables such as age, educational background, and years of experience in current position.

Several researchers suggest that leadership style is influenced by age (Burne, 1986; Cerasoli, 1987; Cheri, 1976; Coleman, 1988; Gottlieb, 1990; Jones, 1985; Monaco, 1986). However, Brown, 1986; Cagle, 1988; Dhanasobhon, 1983; Holt, 1986; Khair, 1984; Martin, 1990; McMurray, 1987; Roberts, 1986; and Wisessang, 1988, have reported no relationship between age and leadership style.

Regarding the academic degree or educational background earned by an individual, Adams (1988), Burne (1986), Cheri (1976), Hadley and Andrews (1978), Johnson, Peterson, & Kahler (1968), Jones (1985), and Villarreal (1985) found this variable to be related to leadership style, whereas Brown (1986), Cagle (1990), Cimperman (1986), Cole (1984), Dhanasobhon (1983), Holt (1986), Martin (1990), McMurray (1987), Ortyoyande (1984), and Wisessang (1988) concluded differently.

Adams (1988), Cerasoli (1987), Monaco (1986), and Gottlieb (1990) determined that years of experience are related to leadership style. However, some researchers concluded differently (Acee, 1990; Brown, 1986; Cagle, 1990; Cole, 1984; Dhanasobhon, 1983; Gilmore, 1984; Jones, 1985; Khair, 1984; Martin 1990; McMurray, 1987; Roberts, 1986; and Wisessang, 1988).

There are sufficient inconsistencies in these studies to warrant further investigation into the relationship between leadership styles and such demographic variables as age, educational background, and years of experience in current position in a cross-cultural setting.

In summary, age, educational background, and years of experience in current position were investigated as demographic variables compared to leadership styles in this research study. The Situational Leadership II theory was utilized as the theoretical framework of this dissertation.

### Statement of Hypotheses

The following hypotheses were developed to test the relationships of government hospital administrators' leadership styles, style flexibility, and style effectiveness to each selected variable:

1. There is a significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership styles of Thai government hospital administrators.
2. There is a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.
3. There is a significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.
4. There is a significant relationship between the primary leadership styles of the Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.
5. There is a significant relationship between the flexibility of the leadership style of Thai government hospital administrators as (perceived by others) and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.

6. There is a significant relationship between the effectiveness of the leadership style of Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.

### **Definition of Terms**

A number of terms were used in the pursuit of this review and study. This study was intended for an audience which included lay board members and others who may not be totally familiar with health care and administration vocabulary and terms. In order to avoid ambiguities, definitions of terms were presented to ensure uniqueness in the written expressions of this study. Therefore, identification of some terminology is exhibited at this point.

Leadership: Leadership is the process of influencing--literally meaning "to flow from." It is spiritual and emotional, dramatic and passionate. Leadership is vision with a purpose. It is communication, empowerment, and self-mastery. It is more than doing the thing right. Leadership is doing the right thing (Jeffries, 1992).

Leadership style: According to Blanchard et al. (1985), "leadership style" refers to the way the leader supervises or works with someone. It is how he/she behaves, over time, when trying to influence the performance of

others. Leadership style describes a characteristic manner of behavior. This study used the styles of leadership proposed by Blanchard et al. (1985) in the Situational Leadership II theory. The four styles are directing, coaching, supporting, and delegating (Zigarmi et al., 1991).

Primary leadership style: This term refers to the leadership style which the leader utilized the most among the four styles: directing, coaching, supporting, and delegating of the Situational Leadership II theory (Zigarmi et al., 1991). The primary leadership style was obtained from the highest total score or frequency under the "Style Flexibility" on the LBA II-Scoring sheet (*see Appendix C*). If the highest score for any administrators was the same for more than one leadership style (i.e., two or more columns had identical scores), his/her primary leadership styles were labeled by those styles in a separate category (Blanchard et al. 1991c).

Leadership style flexibility: This term refers to the degree to which the leader is able to vary his/her leadership styles through directing, coaching, supporting, and delegating styles of the Situational Leadership II theory (Zigarmi et al., 1991). Style flexibility can be identified by the score obtained from the LBA II-Self instrument (Blanchard et al., 1991c).

Leadership Style Effectiveness: This term refers to the ability of the leader to vary his/her leadership styles and the appropriateness of his/her behavior to each given situation in obtaining a desired outcome. In other

words, it is the behavior utilized by the leader that fits the given situation and meets the expectations or preferences of the followers (Hersey & Blanchard, 1988).

Demographic variables: This term is concerned with the individual characteristics of the leaders that relate to their personal profiles. The variables are: age, educational background, and years of experience in current position (*see Appendix D*).

Hospital administrator: This term refers to the person responsible for the management of hospitals on a 24-hour-a-day basis and for maintaining an environment that is supportive of patient care. The hospital administrator has the planning, corporate coordinating, and day-to-day responsibilities for managing and directing the hospital or facility (Ministry of Public Health, Bangkok, Thailand, 1990; Wilson & Neuhauser, 1982).

Government hospital administrator: This term refers to the hospital administrators who work as directors or chief executive officials of government-operated general hospitals. Each general hospital administrator represents the Thai Ministry of Public Health in the role of government health care agency in his/her territory. He/she is acting as a health care governor of each province in Thailand (Health Education Division and Health Planning Division, 1991).



Supervisor of government hospital administrator: This term refers to the Provincial Chief Medical Officer (PCMO) (*see Appendix E*). Current PCMO, are physicians who are nominally responsible for both administration and support of all medical and health facilities in the province including the General Hospital and Provincial Health Office. In practice, the day-to-day operation of the general hospital is left to the hospital director (in this dissertation, "hospital administrator") and the PCMO tends to focus on the supervisory aspects (Ministry of Public Health, Bangkok, Thailand, 1990) (*see Appendix F*).

General hospital: This term refers to general hospitals which are accredited and recognized by the Thai Ministry of Public Health as well-equipped, approximately 500-bed hospitals in 69 provinces of Thailand (*see Appendices F and G*). These hospitals are predominantly utilized by people in the immediate area of the 69 provincial capitals in nine zones excluding Bangkok, the capital of Thailand.

### **Scope and Delimitations**

The investigation focused on the relationships of government-operated hospital administrators' leadership styles to each of the following demographic variables: age, educational background, and years of experience in current position. Since there was only one female among the

hospital administrators who were the sample of this study, gender was not used as a demographic variable for the analysis (*see Appendix D*). The study also examined the interrelationships of the above-selected variables to determine if there was a predictable relationship to leadership style. It also emphasized the relationship of administrators' perception and their supervisors' perception toward their leadership styles, style flexibility, and style effectiveness.

The concerns of this study centered around identification and comparison, but did not necessarily allude to any corrective action. It was not the intent of this research study to change or to directly influence these leaders, but to identify the variations in their leadership styles. As Kaplan (1964) stated, the concept of any study is expressed with the thought that, fortunately science does not demand that bias be eliminated, but only that our judgment take it into account.

The limitations of this study were the following:

1. The sample of this study was limited to the government hospital administrators of all the general hospitals in Thailand and these perceptions were measured only when the respondents completed the LBA II-Self and the LBA II-Other instruments.

2. The leadership styles discussed here were limited to those styles in Situational Leadership II theory as put forth by Blanchard et al. (1985) and identified through the LBA II-Self and the LBA II-Other instruments.

Blanchard et al. (1985) stated: "Self-perception of how the leader behaves is interesting but it tells the leader only how he/she intend to act. Unless it matches the perceptions of others it is not very helpful" (Blanchard et al., 1985, p. 20). In order to illustrate the above thought it should be mentioned that Hersey and Blanchard (1988) defined leadership style as follows:

The leadership style of an individual is the behavior pattern that person exhibits when attempting to influence the activities of others as perceived by those others. This may be very different from the leader's perception of leadership behavior, which we shall define as self-perception rather than style. (p. 116)

However, in this dissertation it was difficult to avoid using the term "style" when studying self-perception because the LBA II-Self instrument itself uses the term "style" instead of "self-perception," as is illustrated in the LBA II-Self in the following statement: "The purpose of the LBA II-Self is to provide you with information about your perceptions of your own leadership style" (p. 1).

Therefore, for the research questions and research hypotheses of this dissertation, if "self-perception" is not specified, the others-perception is meant as the leadership style of the leaders.

### **Organization of the Study**

This study is presented in five chapters as follows:

1. Chapter 1 includes the following topics: (1) an introduction, (2) statement of problem, (3) purpose of the study, (4) significance of the study, (5) theoretical framework, (6) statement of hypotheses, (7) definition of terms, (8) scope and delimitations of the study, and (9) organization of the study.

2. Chapter 2 contains a background of Thai hospitals and their administration, a review of relevant literature focusing on the definitions of leadership, the history and evolution of leadership theories, the review of Situational Leadership theories, the demographic variables in leadership studies, the research studies related to leadership behavior of hospital administrators, and a summary.

3. Chapter 3 contains a description of the research methodology utilized in the study. The presentation is divided into the following sections: (1) design of the study, (2) operational variables, (3) description of the population and the sample, (4) procedures, (5) description of the research instrument, (6) reliability and validity of the instrument, (7) statistical methodology, and (8) chapter summary.

4. Chapter 4 contains an analysis of the data and the results. Chapter 5 presents upon a summary of the study, a discussion, a conclusion, and recommendations.

## **CHAPTER II**

### **A REVIEW OF THE LITERATURE**

#### **Introduction**

This chapter contains related literature which provides the setting for the development of this study. Literature related to research that has contributed in a theoretical or a practical perspective was explored for its contribution to situational leadership theory. The areas explored fall into these following sections: (1) background of Thai hospitals and their administration, (2) definitions of leadership, (3) the history and evolution of leadership theories, (4) review of Situational Leadership theories, (5) Situational Leadership II theory, (6) demographic variables in leadership studies, (7) the research studies related to leadership styles of hospital administrators, and (8) summary.

#### **Background of Thai Hospitals and Their Administration**

While studying the background of Thai hospitals and their administration, the historical, geographical, population, and demographic areas were reviewed.

Western medicine came rather late to Thailand in spite of a four-century contact with Western nations. Contact with the Portuguese, French, and British during the 16<sup>th</sup>, 17<sup>th</sup>, and 18<sup>th</sup> centuries produced little in the way of transfer of Western medicine, because of political reasons and the limited impact these countries had on Thailand. It was left to the American Presbyterian Mission Board to seriously introduce Western medicine into the country following its arrival in 1828 (Ministry of Public Health, Bangkok, Thailand, 1990, p. 6).

In Thailand, the Ministry of Public Health has the responsibility for the organization, management, and administration of public health services and most of the medical services of the government, especially in the rural areas. Thai health services of the government sector are concentrated in the provincial areas. Each of the nation's provinces has a Provincial Health Office, headed by a physician called the Provincial Chief Medical Officer (PCMO), who is nominally responsible for both administration and support of all medical and health facilities in the province including the General Hospital and Provincial Health Office. In other words, a Provincial Chief Medical Officer is a supervisor of a general hospital director (in this study called "hospital administrator") in his/her area (*see Appendix F*). "In practice, the day-to-day operation of the General Hospital is left to a hospital director and the Provincial Chief Medical Officer tends to focus on the

supervisory aspects" (Ministry of Public Health, Bangkok, Thailand, 1990, p. 29)

At present, there are over 1,130 hospitals in Thailand including government-operated and private hospitals (*see Appendix G*). Among these hospitals there are 69 general hospitals which are operated by government. These general hospitals serve people in the immediate area of the provincial capital. Each general hospital administrator represents the Ministry of Public Health in a role of government health care agency in his territory; in other words, he/she is acting as a health care governor of each province in Thailand. The role of these general hospital administrators is very crucial in Thailand (Health Education Division and Health Planning Division, 1991). Unfortunately, according to the Thai Ministry of Public Health, the legal structure of general hospitals in Thailand has not allowed the development of leadership for hospital administration. Technically, only physicians are appointed to these positions (Thai National Health Care Association, 1991). These physicians are not professional administrators, but each operates with his/her own style of leadership, and are responsible for the national health care administration!



### Definitions of Leadership

Bennis and Nanus (1985) noted that there were more than 350 definitions of leadership recorded in the literature. In many respects, leadership is "whatever people believe it to be" (Cunningham, 1985, p. 17).

Listed below are some representative definitions:

Leadership is the activity of influencing people to cooperate toward some goals which they come to find desirable. (Tead, 1935, p. 20)

Leadership is the process of influencing the activities of an organized group in efforts toward goal setting and goal achievement. (Stogdill, 1950, p. 4)

Leadership is the process by which an agent induces a subordinate to behave in a desired manner. (Bennis, 1959, p. 261)

Leadership is leaders inducing followers to act for certain goals that represent the values and the motivations--the wants and needs, the aspirations and expectations--of both leaders and followers. And the genius of leadership lies in the manner in which leaders see and act on their own and their followers' values and motivations. (Burns, 1979)

Leadership is the art or process of influencing people so that they will strive willingly and enthusiastically toward the achievement of group goals. (Koontz, Donnell, & Weihrich, 1984, p. 504)

Leadership is a general function made up of many specific skills and abilities. An individual leads by communicating with his staff, motivating them, monitoring their performance, acting as an example, helping and coaching, and, most importantly, by making decisions. (Kazemek, 1988, p. 98)

Leadership is the process of influence, literally meaning, "to flow from." It is spiritual and emotional, dramatic and passionate. Leadership is vision with a purpose. It is communication and empowerment and self-mastery. It is more than doing the thing right. Leadership is doing the right thing. (Jeffries, 1992, p. xi)

A review of these seven leadership definitions indicates that whereas the first definition listed was stated in 1935 and the last one was proposed in 1992, they closely coincide. One common cord running through these seven definitions is that leadership is an operation whereby one individual employs his/her influence over others in the group. The important connotation of this common feature is that leadership develops only when there is interaction between individuals (Donnelly, Gibson, & Ivancervich, 1990). Hersey and Blanchard (1982), Koontz and O' Donnell (1959), Tannenbaum, Weschler, and Massarik (1959), and Terry (1960) agreed that historically, leadership has been defined in numerous ways by numerous authors with most definitions containing, at least in part, a common theme--a process of influencing people toward the accomplishment of a goal or task.

### **The History and Evolution of Leadership Theories**

Over three thousand studies have been conducted during the last 70 years in the area of leadership, and dozens of theories and models have been proposed (Hersey & Stinson, 1980). Zorn and Violanti (1993) reported that the study and teaching of leadership is yet a major scholarly concern of the 20<sup>th</sup> century. As evidence, the latest version of the Handbook of Leadership (Bass, 1990) contains more than 7,500 references, and Rost (1991) found a steady rise in the number of published writings on leadership in each decade

of this century, with the 1970s and 1980s each witnessing more than a 100% increase in writings compared to the preceding decade. In addition, several universities now offer academic degrees in leadership studies (Rost, 1991).

The concept of leadership may be as old as the history of humankind's civilization. A closer study of leadership theory in the early part of this century showed that it evolved around two major concepts--scientific management and human relations. The former was invariably called structure or task-oriented, whereas the latter was considered people-oriented leadership style. A number of studies indicated that an effective leader must have balance between scientific management and human relations (Clarke, 1984; Mullins, 1983; and Spivey, 1983).

Scientific management was championed by Frederick Winslow Taylor in the early 1900s. The basis for his scientific management was technological in nature. In his theory, Taylor (1947) stated that the best way to increase output was to improve the techniques or methods used by workers (Hersey & Blanchard, 1988). This led to use and manipulation of people as machines by their leaders. Management tended to neglect human affairs and emotions. This meant that "workers had to adjust to the management and not management to the people" (Hersey & Blanchard, 1982, p. 84). The function of a leader under scientific management was to set up

and enforce performance criteria to meet organizational goals. The leader focused mainly on the organization over that of the individual worker.

In the 1920s and early 1930s, Taylor's scientific management was challenged by the human relations movement initiated by Elton Mayo (1945) who contended that, in addition to using the best technological methods to improve output, it was beneficial to the management to look into human affairs as well. He emphasized that the strength of an organization lay in the interpersonal relations developed within the working unit. The organizational set-up was developed around the workers, taking into account human feelings and attributes. Under the human relations system, the leader's function was to facilitate cooperative goal attainment among workers while providing opportunity for their personal growth and development. The main focus, contrary to that of scientific management theory, was on the individual worker's needs rather than on the needs of the organization. The recognition of these two concerns, the worker's and organizational needs, has characterized the writings on leadership ever since the conflict between the scientific management and human relation schools of thought became apparent (Hersey & Blanchard, 1988).

Looking specifically at leadership, it was found that basic approaches to leadership have moved through three rather dominant phases: trait, attitudinal, and situational (Hersey & Blanchard, 1988).

## **Trait Approaches**

During 1930s and 1940s, trait theories were predominant. The earliest leadership studies tried to determine what makes a good leader by examining the inherent traits of leaders. It was believed that if a leader was endowed with superior qualities that differentiated the leader from the follower, it should be possible to identify those qualities (Bass, 1990). As a result, researchers attempted to find a set of identifiable, individual characteristics that could differentiate between effective and ineffective leaders. However, the comparison of leaders by various physical, personality, and intelligence traits resulted in little agreement among researchers (Koontz et al., 1984). Stogdill (1948) agreed that a review of the research literature using this trait approach to leadership has revealed few significant or consistent findings. As he concluded,

A person does not become a leader by virtue of some combination of traits, but the pattern of the personal characteristics of the leader must bear some relationship to the characteristics, activities and goals of the followers. Thus, leadership must be conceived in terms of interactions of variables which are in constant flux and change. (p. 64)

In 1961, Jennings (1961) supported this:

Research has produced such a variegated list of traits presumably to describe leadership that, for all practical purposes, it describes nothing. Fifty years of study have failed to produce one personality trait or set of qualities that can be used to discriminate leaders and nonleaders. (p. 2)

Studies conducted by Bird (1940), Gouldner (1950), and Jenkins (1947) all implied that no prevalent qualities could distinguish leaders from other individuals in a group or organization. Reddin (1970) also summarized the weaknesses of the trait approach as follows:

The weaknesses of the trait approach are that there is no agreement on the best traits that fit all situations, that there is no evidence that one group of traits predict effectiveness generally, and that there are now well over a thousand different traits to deal with. (p. 20)

Horace and Moser (1989) added that early leadership studies focused upon individual characteristics, but evidence soon became clear that it was impossible to predict a potential for leadership based on personal traits. There were attempts to determine if certain traits of personality, intelligence, physique, or perception were either associated with those who lead or could be used to distinguish those who might become leaders; however, the evidence seemed clear that leaders did not possess common traits and that it was not possible to predict a potential for leadership on the basis of personal traits.

After the collection of leadership traits became too large to manage or make sense of, researchers began to focus on leadership style and on what leaders do in their capacities as leaders. Concentration upon an analysis of the style of leaders, instead of the notion of leadership as a trait, has brought

about an increased understanding of leadership phenomena. As Dubil (1983) commented:

The shift of emphasis from leadership trait to the analysis of leader behavior produces methodological advantages. It permits dealing directly with observable phenomena without making a priori assumptions about the identity or structure of whatever capacities may or may not undergird these phenomena. (p. 33)

### **Attitudinal Approaches**

The main period of the attitudinal approaches to leadership occurred between 1945, with the Ohio State and Michigan studies, and mid-1960 with the development of the Managerial Grid (Hersey & Blanchard, 1988). By attitudinal approaches, Hersey and Blanchard (1988) mean approaches that use paper and pencil instruments such as questionnaires to measure attitudes or predispositions toward leader behavior. The dimensions of the Managerial Grid, Concern for Production, and Concern for People are attitudinal. Concern may be defined as a predisposition or feeling toward or against production and people.

The introduction of the Managerial Grid theory by Blake and Mouton (1964) was a good example of the concern for people and their relation to task performance. The theory identified the varying styles leaders might use in dealing with people and situations.

During the late 1940s and early 1950s, three attitudinal approaches to leadership were the Ohio State Studies; the Michigan Studies, including Rensis Likert's work; and the Managerial Grid (Hersey & Blanchard, 1988). The University of Michigan group investigated the relationship between leadership style and effectiveness. The University of Michigan studies identified two basic leadership styles: production-centered style and employee-centered style. The Ohio State studies concentrated on two theoretical concepts--task accomplishment and the development of personal relationships (Stogdill & Coons, 1957; Szilagyi & Wallace, 1980).

Using the earlier Michigan studies as a starting place, Rensis Likert did some extensive research to discover the general pattern of management used by high-producing managers in contrast to that used by other managers. He found that "supervisors with the best records of performance focus their primary attention on the human aspects of their subordinates' problems and on endeavoring to build effective work groups with high performance goals" (Likert, 1961).

In the Managerial Grid, five different types of leadership based on concern for production (task) and concern for people (relationship) are located in four quadrants similar to those identified by the Ohio State studies (Blake & Mouton, 1964). The five leadership styles are identified as (1) impoverished, (2) country club, (3) task, (4) middle-of-the-road, and (5)



team. Blake, Mouton, and Williams (1981) used their Managerial Grid extensively in organization and management development programs.

### **Situational Approaches**

Although attitudinal approaches use the predispositions or feelings toward or against production and people to study leader behavior, situational approaches use the observed behavior dimensions of task behavior and relationship behavior to assess leadership style. Situational leadership thus describes how people are actually behaving (Hersey & Blanchard, 1988).

Hersey and Blanchard (1988) stated:

The focus in situational approaches to leadership is on observed behavior, not on any hypothetical inborn or acquired ability or potential for leadership. The emphasis is on the behavior of leaders and their group members (followers) and various situations. With this emphasis on behavior and environment, more encouragement is given to the possibility of training individuals in adapting styles of leader behavior to varying situations. Therefore, it is believed that most people can increase their effectiveness in leadership roles through education, training, and development. (p. 105)

During the 1960s, leadership focused on the more complex situational theories of leadership style effectiveness. Among situational models and theories, the Fieldler's Contingency Model, the House-Mitchell Path-Goal Theory, the Vroom-Yetten Contingency Model, and the Hersey-Blanchard Tri-Dimensional Leader Effectiveness Model have received wide attention in leadership research.

Fiedler's (1967) contingency theory of leadership was one of the first models. His theory postulated that group productivity was dependent on the match of leadership orientation and the situational favorableness. Leadership orientation was operationalized in terms of high or low scores on the Least Preferred Co-Worker (LPC) scale, which he found to be related to group performance. Fiedler (1967) found that task-oriented leadership was related to effectiveness in moderately favorable situations.

In the early 1970s, House advanced a path-goal theory of leadership effectiveness (House & Mitchell, 1974). The foundation of this theory is the expectancy theory of motivation. House's (1971) path-goal theory is concerned with the influences of specific leader behavior on subordinate motivation and satisfaction, rather than the more general issues of decision making and performance (Chemers, 1984).

Vroom and Yetten's (1973) Normative Contingency theory focuses on decision-making activities. The theory resumed the decision analysis model which was based on the assumption that situational variables interacting with personal attributes or characteristics of the leaders result in leader behavior that can affect organizational effectiveness. Hersey and Blanchard (1988) wrote, that according to Vroom and Yetten, the leader has the ability to vary his or her style to fit the situation and that people can develop into more effective leaders.

The situational model of leadership by Hersey and Blanchard (1982, 1988) proposes four basic behavior styles of leadership in terms of task behavior and relationship behavior. The four basic leader behavior styles are (1) telling, high task and low relationship; (2) selling, high task and high relationship; (3) participating, high relationship and low task; and (4) delegating, low relationship and low task. These four basic styles depict essentially different leadership styles. This model expresses that the effectiveness of the leader depends on how his/her leadership style interrelates to the situation in which he/she operates.

In summary, the study of the history and evaluation of leadership theories included three basic leadership approaches that are considered as dominant phases. They were presented respectively as follows: (1) trait, (2) attitudinal, and (3) situational approaches (Hersey & Blanchard, 1988).

### **Review of Situational Leadership Theories**

At present the leadership theory accepted by several researchers is known as the Situational Leadership theory (Bass, 1990; Behling & Rauch, 1985; Bevoise, 1984; Blank, Weitzel, & Green, 1990; Bogue, 1985; Callahan, Fleenor, & Knudson, 1986; Cawelti, 1979; Glickman, 1985; Goodson, McGee, and Cashman, 1989; Hall, Rutherford, Hord, and Huling, 1984; Hersey & Blanchard, 1988; Horace & Moser, 1989; Kleiner, 1981;

Vecchio, 1987; and Zigarmi et al., 1991). As mentioned in the history and evolution of leadership theories, the situational approaches of leadership have filled the literature. However, there are four that have received broad attention in leadership research: (1) the Fiedler's Contingency Approach, (2) the House-Mitchell Path-Goal Theory, (3) the Vroom-Yetten Contingency Model, and (4) the Hersey-Blanchard's Situational Leadership Model. These leadership theories and models have tried to explain the characteristics of the group in which the leader operates and the situation with which the group must deal.

According to the Situational Leadership theories, the three main components of the leadership process are the leader, the follower, and the situation. Hersey and Blanchard (1988) cited:

Situational approaches to leadership examine the interplay among these variables in order to find causal relationships that will lead to predictability of behavior. You will find a common thread among the situational approaches. This common thread is that all situational approaches require the leader to behave in a flexible manner, to be able to diagnose the leadership style appropriate to the situation, and to be able to apply the appropriate style. (p. 106)

### **Fiedler's Contingency Approach**

Fiedler's (1967) Contingency theory postulated that the "effectiveness of a group is contingent upon the relationship between leadership style and the degree to which the group situation enables the leader to exert

influence" (p. 15). Fiedler's (1967) principal tool in investigating leader effectiveness was the Least Preferred Co-Worker (LPC) measure.

Fiedler's (1967) Least Preferred Coworker scale (LPC) is the instrument used to operationalize leadership style in Fiedler's Contingency model of leadership, the most researched theory in leadership studies (Zorn & Violanti, 1993). A low LPC leader, who assigns largely negative attributes to the least preferred co-worker, is seen as primarily task motivated, whereas a high LPC leader is seen as relationship motivated. However, there are different interpretations of what the LPC actually measures. Fiedler (1967) claimed, and numerous studies support the claim (Bass, 1990), that a high LPC score reflects a relations orientation and a low LPC score reflects a task orientation. A person who is task oriented "reject(s) those with whom (he or she) would least like to work" and a person who is relationship oriented "perceives even (his or her) worst coworker in a relatively positive light" (Randolph & Blackburn, 1989, p. 317). Once the style of the leader is determined, the work situation is then evaluated for routine or complex task structure, the group atmosphere of the followers, and the position power of the leader (Fiedler, 1967).

In summary, according to Fiedler, there is a best style in a given situation. He claimed the best style in a situation with a favorable leadership position would be a task-oriented style. The best style is an intermediate

situation which would not have a complex task or a negative group atmosphere but would be a relations-oriented style. The best style in an unfavorable situation would require a task-oriented leadership style (Fiedler, 1967). Immegart (1988) credited that Fiedler's work served to establish the value of the contingency approach for the study of leadership. However, Fiedler's (1967) Contingency theory is still the subject of considerable controversy.

### **House-Mitchell Path-Goal Theory**

In the early 1970s, House and Mitchell advanced a path-goal theory of leadership effectiveness (House & Mitchell, 1974). The foundation of this theory is the Expectancy theory of motivation. Path-goal refers to the Expectancy theory concepts of effort-to-performance and performance-to-reward expectancies and valences (Szilagyi & Wallace, 1980). Expectancy theory holds that as individual's attitudes or behavior can be predicted from (1) the degree to which the job is seen as leading to various outcomes (expectancies) and (2) the evaluation of those outcomes (valences) (Szilagyi & Wallace, 1980).

According to this theory, the implications for leadership is that followers are motivated by leader behavior to the extent the behavior influences expectancies (path-goal) and valences (attractiveness) (Finnick,

1984). The four leader behaviors House and Mitchell identified are: (1) instrumental behavior, the planning, organizing, controlling and coordinating of followers' activities by the leader; (2) support behavior, includes giving support consideration to the needs of the followers; (3) participation behavior, characterized by sharing of information and an emphasis on consultation with followers; (4) achievement-oriented behavior, characterized by setting challenging goals, and expecting followers to perform at the highest level (House & Mitchell, 1974, p. 84).

Four leadership styles are identified in the path-goal theory: (1) supportive leadership, (2) directive leadership, (3) participative leadership, and (4) achievement-oriented leadership. The situational factors identified in path-goal theory are: the personal characteristics of followers and the environment in which they must deal (House & Mitchell, 1974).

Yukl (1989) cited that the path-goal theory provides a conceptual framework to guide researchers in identifying potential situational variables. The proponents of the theory intended it to be only a tentative explanation of the motivational effects of leadership behavior and House and Mitchell did not attempt to include all of the variables that may be relevant. When the followers are performing relatively unstructured tasks, the path-goal theory proposes that a leadership style high on task behavior and low relationship behavior will be most effective.

### **Vroom and Yetten's Contingency Model**

The Vroom and Yetten model (1973) is based on the leader behavior in the decision-making process. The decision is measured in terms of quality and acceptance regarding the effect on the followers. The effect of participation in decision quality depends upon the distribution of important information and problem-solving expertise between the leader and followers. The model assumes that participation will result in good quality decisions.

The procedures for decisions in the model involve two variables of autocratic decision, two variables of consultative decision, and one variety of joint decision making by leader and followers as a group (Yukl, 1989). The model establishes that the decision procedures are effective depending on:

1. The amount of relevant information possessed by leaders and followers
2. The likelihood that followers will accept an autocratic decision
3. The likelihood that followers will cooperate if allowed to participate
4. The amount of disagreement among the followers with respect to their preferred alternative
5. The extent to which the decision problem is unstructured and uniqueness creative problem solving (Owens, 1987, p. 145).



In 1988, the model was revised. Vroom and Yago (1988) included criteria hierarchically classified and a single procedure by applying the criteria. This model is supported and respected by such researchers as Hersey and Blanchard (1988). Immegart (1988) added that this model is a diagnostic tool for managers or designated leaders "to be used in specific situations in order to determine the appropriate degree of participation in decision making activity" (p. 265).

### **Hersey-Blanchard's Situational Leadership Model**

Hersey and Blanchard developed an integrated model of leadership based on Situational Leadership theory called Hersey and Blanchard's Situational Leadership Theory. This theory synthesized Blake and Mouton's (1964) Managerial Grid postulations, Reddin's (1970) 3-D Effectiveness topology, and Argyris' (1984) Maturity-immaturity theory (Blank et al., 1990; Hersey & Blanchard, 1988; Horace & Moser, 1989). The basic assumption of this theory is that there is no one best style of leadership. Successful leaders are those who can adapt their styles to fit the maturity level of the people they are attempting to influence (Hersey & Blanchard, 1988).

This theory attempts to use the maturity or development level--defined as ability plus willingness--of the follower as a moderate variable on the

leader's use of task and relationship behavior. Maturity or development level is a function of the follower's task-related skills, knowledge of the task, abilities, self-confidence, willingness to complete the task, and motivation. The follower's maturity or development level determines the type of behavior he/she needs from the leader. As the follower matures or becomes more developed, he/she needs differing amounts of task and relationship behavior from the leader (Zorn & Violanti, 1993).

The components of this model are defined as follows:

Task behavior--the extent to which the leader engages in spelling out the duties and responsibilities of an individual or group. These behaviors include telling people what to do, how to do it, when to do it, where to do it, and who is to do it. (Hersey & Blanchard, 1988, p. 172)

Relationship behavior--the extent to which the leader engages in two-way or multi-way communication. The behaviors include listening, facilitating and supportive behavior. (p. 172)

Readiness level--the extent to which a follower has the ability and willingness to accomplish a specific task. People tend to be at different levels of readiness on the task they are being asked to do. (p. 174)

The four different levels of maturity are: (1) low (unable and unwilling), (2) low to moderate (unable but willing), (3) moderate to high (able but unwilling to do what the leader wants), and (4) high (able and willing to take responsibility). The level of readiness determines the optimal level of leadership behavior detected through the four styles called: telling, selling, participating, and delegating (Hersey & Blanchard, 1988).

According to Situational Leadership theory, as the level of follower maturity increases, the leader should use more relationship-oriented behavior and less task-oriented behavior until followers reach a moderate level of maturity. As follower maturity increases beyond their level, the leader should then decrease the amount of relationship-oriented behavior, while continuing to decrease the amount of task-oriented behavior. Flexibility is needed in the leader's behavior because regression or advancement could occur in follower behavior (Hersey & Blanchard, 1988).

Hersey and Blanchard's (1988) Situational Leadership theory was a means to assist those in leadership positions to diagnose their situations in order to develop and/or enhance their leadership skills. The use of Situational Leadership theory provided leaders with an understanding of how their leadership style is perceived by themselves and by their supervisors and followers (Hersey & Blanchard, 1988).

In summary, situational approaches are a relatively recent trend in leadership theorizing. Situational theories suggest that leaders can and should alter their leadership style depending upon the situation (Zorn & Violanti, 1993). According to Bass (1990), Situational Leadership theory provides a broad framework for the analysis of leader behavior that has the capability of synthesizing other theories of motivation, organizational development, and leader behavior. Kleiner (1981), after surveying

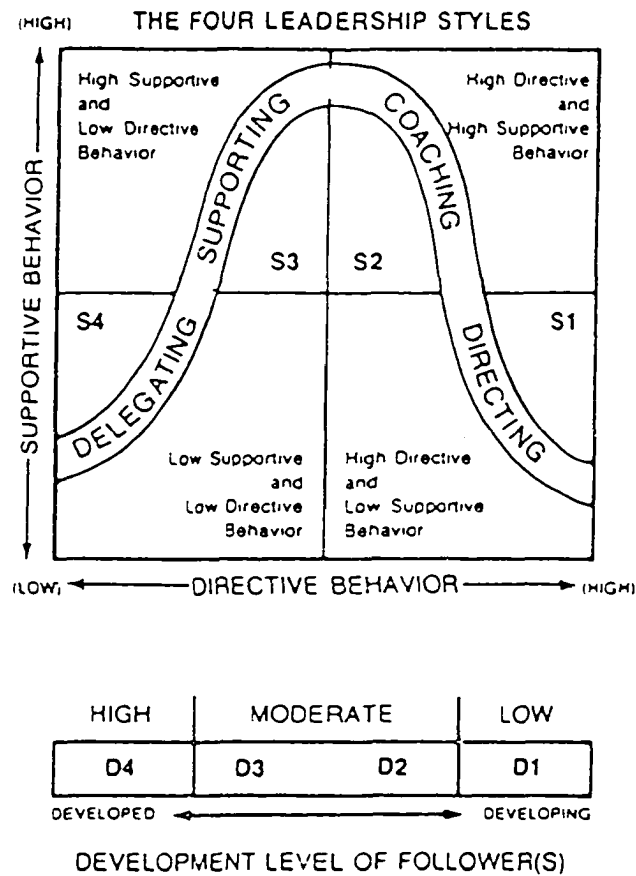
alternative theories of leadership, concluded that Situational Leadership theory represents the best integration of ideas concerning leadership into one comprehensible and relatively understood model. Zorn and Violanti (1993) stated that Situational Leadership theory is among the most useful instructional tools that researchers have produced to help assess the knowledge of leadership styles.

### **Situational Leadership II Theory**

The Situational Leadership II theory is a more recent theory developed by K. Blanchard et al. (1985) and is based on a revision of the theory referred to as Hersey and Blanchard's (1982) Situational Leadership theory (Zigarmi et al., 1991). The theorists adapted Hersey and Blanchard's (1982) Situational Leadership by making the following changes in the Situational Leadership Model:

1. The directing style (S1) in the original model was called "telling."
2. The coaching style (S2) in the original model was called "selling."
3. The supporting style (S3) in the original model was called "participating."
4. The development level was originally called "maturity level."
5. Directive behavior and supportive behavior were originally called "task behavior" and "relationship behavior."

## SITUATIONAL LEADERSHIP II



**Figure 1.** The Situational Leadership II Model.

From Leadership and the one minute Manager (p. 68) by Kenneth Blanchard, Patricia Zigarmi, and Drea Zigarmi, 1985, New York, NY: William Morrow and Company. Copyright 1985 by William Morrow and Company. Reprinted by permission.

Situational Leadership model displays the relationship between development level and leadership style was shown in figure 1.

In other words, the four leadership behaviors or styles have different labels in that they reflect a combination of directive and supportive behaviors: directive, coaching, supporting, and delegating. In the Situational Leadership II model the development level was determined by the degree of competence and commitment employed by a follower to perform a particular task without supervision. Hersey and Blanchard (1988) explained that anytime a person is not performing well without supervision, it is usually a competence problem, a commitment problem, or both (p. 49).

Blanchard, Zigarmi, and Zigarmi (1987) illustrated:

We use the word competence, rather than ability, because people often confuse ability with potential. They use ability to describe the skills a person is born with. Competence, on other hand, can be developed with appropriate direction and support. It is a function of knowledge or skills that can be gained from education, training, and work experience. Commitment is a combination of confidence--a feeling of being able to do a task well without much supervision--and motivation, a person's interest and enthusiasm in doing the task. (p. 14)

The four development levels are:

1. Low or D1--Low competence but high commitment
2. Low to moderate or D2--some competence but low commitment
3. Moderate to high or D3--high competence but variable commitment
4. High or D4--high competence and high commitment.

Blanchard et al. (1985) summarized the relationships between the four development levels and the four leadership styles--The D's and the S's match up--as follows:

Directing (S1) is for people who lack competence but are enthusiastic and committed (D1). They need direction and supervision to get them started.

Coaching (S2) is for people who have some competence but lack commitment (D2). They need competence but lack commitment (D2). They need direction and supervision because they're still relatively inexperienced. They also need support and praise to build their self-esteem, and involvement in decision-making to restore their commitment.

Supporting (S3) is for people who have competence but lack confidence or motivation (D3). They do not need much direction because of their skills, but support is necessary to bolster their confidence and motivation.

Delegating (S4) is for people who have both competence and commitment (D4). They are able and willing to work on a project by themselves with little supervision or support. (p. 57)

Blanchard et al. (1987) explained the difference of the development level in their model from the maturity level in Hersey and Blanchard's Situational Leadership model (1982) in the following statement:

The commitment aspect of D1 and D2 has been changed significantly from the original M1 and M2 developed in Hersey and Blanchard, Management of Organizational Behavior. M1 was considered unable and unwilling, while M2 was thought of as unable and willing. (p. 16)

The leader moves from directing a new follower--one who is low in competence and high in commitment--to delegating to a developed follower--one who is high in competence and high in commitment. Compared to the

original version of situational leadership, the major substantive change is that the lowest development level in Blanchard's revision is considered high in commitment (or motivation) and the next lowest is considered low in commitment. By comparison, the original version considered someone low in motivation to be less developed than someone high in motivation. The rationale that caused Blanchard to switch the two development levels seems to be that newcomers to a task typically start out motivated and become less so as they learn of the complexities and difficulties of performing effectively.

In summary, according to the Situational Leadership II theory, a situational leader changes his/her style depending on the person he/she is working with and the situation. This does not mean that a situational leader is inconsistent in treating people. Usually, being consistent sounds like treating everyone the same way. But, a situational leader has a different definition of being consistent. According to a situational leader, being consistent is "using the same leadership style in similar situations" (Hersey & Blanchard, 1988, p. 32). Zigarmi et al. (1991) claimed that Situational Leadership II theory enables a leader to learn about his/her behavior in the leader's own environment and how that behavior is perceived by others. In addition, the acceptance of situational leadership as a practical, easy-to-understand-and-apply approach to managing and motivating people has been



widespread throughout the world over the last decade and a half (Hersey & Blanchard, 1988, p. 6). Thus, this theory was used as a conceptual framework for this study.

### **Demographic Variables in Leadership Studies**

From the review of studies in leadership, age, educational background, years of experience in current position were widely used as important variables in studying leadership behavior. However, no previous study used the LBA II-Self and LBA II-Other to investigate the leadership style of Thai hospital administrators and their age, educational background, and years of experience working in the current position. Therefore, the above demographic variables were used in this study.

#### **Age**

The findings in research related to age and its relationship to leadership have shown some contradictory evidence. In Thailand, Dhanasobhon (1983) and Wisessang (1988) studied the leadership style of the school administrators in Thailand and found that there were no significant relationships between the administrator's leadership style and their age.

Brown (1986), Khair (1984), Martin (1990), and Roberts (1986) studied the educational leaders and found no relationship between age and

leadership style. Holt (1986) studied the relationships between the self-reported leadership styles and conflict-management techniques of a selected group of hospital middle-management personnel. He found that there were no significant differences between self-reported leadership styles and age.

In 1987, McMurray (1987) studied the relationship between situational leadership effectiveness of administrators in hospitals and principals in high schools in a selected geographical area. Research questions dealt with the relationship between the effectiveness score and age. The studies revealed little or no relationship between effectiveness and age. Cagle (1990) indicated that there were no significant relationships between the nurse executives' leadership style and their age.

On the contrary, Cerasoli (1987) found that leadership behavior of physical therapy department directors as perceived by their subordinates and by their own self-descriptions was significantly related to the age of the administrators. In the study of leadership style among nurse administrators, Gottlieb (1990) reported a relationship between age and leadership style.

In the study of leadership styles among educational administrators, Burne (1986), Cheri (1976), Coleman (1988), Jones (1985), and Monaco (1986) indicated that there was a significant relationship between the leadership style and the age of the administrators.

The age variable, though amply studied, has produced no consistent findings to make it a reliable research factor. In a different cultural context, it would be interesting to explore whether such a relationship exists. Therefore, in this study, age of the hospital administrators was used for such a purpose.

### **Educational Background**

The literature reviewed indicated evidence of some relationship between leadership style and the educational background of an individual. For the purpose of this study, the educational background referred to the field of study which was categorized into "medicine without administrative degree" and "medicine with administrative degree."

Dhanasobhon (1983) and Wisessang (1988), who studied the leadership style of the school administrators in Thailand, found that educational background had no effect on the perceptions of the leadership styles of school administrators.

Holt (1986) studied the relationships between the self-reported leadership styles and conflict management techniques of a selected group of hospital middle-management personnel. He found that there were no significant differences between self-reported leadership styles and educational background. McMurray (1987) studied the relationship between

situational leadership and the effectiveness of administrators in hospitals and principals in high schools in a selected geographical area and revealed little or no relationship between effectiveness and educational background. Cagle (1990) indicated that there were no significant relationships between nurse executives' leadership style and their educational background.

Brown (1986), Cimperman (1986), Cole (1984), Martin (1990), and Ortyoyande (1984) determined no differences between leadership style of educational administrators and the highest degree earned.

In contrast, Adams (1988) found a significant relationship between educational background of nurse administrators and their leadership style. Burne (1986) found that the academic degree of the educational administrator was the most important predictor of the administrator's score in leadership questionnaires in determining their leadership styles. Cheri (1976), Hadley and Andrews (1978), Johnson et al. (1968), Jones (1985), and Villarreal (1985) found educational background to be related to leadership style.

From the literature review the findings have shown some disparities. In spite of these differing conclusions, this study included the relationship between educational background and leadership style to reconfirm whether or not such a relationship exists in Thailand.

### **Years of Experience**

Years of experience in the current position has been traced as one significant variable in the study of leadership style. In Thailand, Dhanasobhon (1983) and Wisessang (1988) studied the leadership style of the school administrators in Thailand and found that years of working experience had no effect on the perceptions of the leadership styles of school administrators.

Holt (1986) found that there were no significant differences between hospital managers' self-reported leadership styles and years of working experience. McMurray (1987) studied the relationship between situational leadership effectiveness of administrators in hospitals and principals in high schools in a selected geographical area. The studies revealed little or no relationship between effectiveness and years of working experience. Cagle (1990) indicated that there were no significant relationships between nurse executives' leadership style and their working experience. Acee (1990) indicated that there was no statistically significant relationship found between length of service as nurse administrators and leadership style.

Roberts (1986) found no significant differences between leadership style and the length of service as school administrators. Gilmore (1984), Jones (1985), and Khair (1984) indicated no relationship between leadership style and experience as educational administrators. Cole (1984) also

determined that years of experience did not affect the perception of leadership style among educational administrators. Brown (1986) and Martin (1990) studied different demographic variables in a sample of educational administrators and found no relationship existed between leadership style and length of services.

In contrast, Adams (1988) and Gottlieb (1990) determined that years of experience is related to leadership style. Cerasoli (1987) found that leadership behavior of hospital department directors as perceived by their subordinates and by their own self-descriptions was significantly related to the working experience of administrators. Monaco (1986) found relationship between the years of administrative experience in the school system and leadership style.

In spite of these differing conclusions in the findings above, the purpose of exploring years of experience in this study was to confirm the actual findings of whether it is related to leadership style.

In summary, from the literature review the findings have shown some disparities when using age, educational background, and years of experience in the current position as demographic variables. In spite of these differing conclusions, this study included the study of the above relationship to reconfirm whether or not such a relationship exists in Thailand.

### **The Research Studies Related to Leadership Styles of Hospital Administrators**

Although researchers on leadership style and its relationship to hospital settings found that the organization, organizational levels, and tasks involved had a direct impact on the leadership style used and its effect on hospital productivity, very few research studies in this area have been conducted (Georgopoulos & Mann, 1962). Most of the above studies are related to the leadership of the nurse administrators and few are related to hospital chief executive officers (in this paper referred to as hospital administrators).

In 1978, Herrod studied on participative management project which was sponsored by the Department of Health and the Social Security Administration in a 330-bed community hospital. He reported that a number of benefits resulted the introduction of the leadership style of participative management. One benefit which evolved was that frank and open discussions became possible between staff of different grades and disciplines. Another important benefit was that inviting staff to give input through ideas and even solutions to problems had helped relieve frustrations and had provided staff with more job satisfaction and motivation. In turn, this created more commitment, helped working relationships, and improved productivity within the hospital.

A research study on medical departments, which included the department of nursing, measured the relationship between leadership style and productivity and efficiency in a number of general acute hospitals, concluded and supported Fiedler's Contingency theory (Taylor, 1978). Taylor concluded that in some situations when a leader tends to be participative, employees tend to be more productive or efficient; and in other situations when a leader tends to be authoritative, employees tend to be as productive or efficient.

In 1982, Goodrich (1982) did a study related to hospital leadership style. She asked hospital, home health care, and educational leaders to rate 117 leadership competencies in regard to their level of importance and proficiency required. All 117 competencies were rated as important or higher. Leadership and quality assurance were rated highest in importance and in the level of proficiency needed.

Kinzer (1982) indicated in his study that the new wave of hospital administrators are better educated individuals, but not nearly so well prepared. This new group is being shaped and developed by on-the-job experience that may be non-related to their formal education. Kinzer (1982) also indicated that the dominating model of a successful hospital administrator includes the following characteristics:



1. He or she will be systems oriented, more than institutionally oriented. This is a key to the marketplace.
2. He or she will have more in common, rather than less, with the business leaders who serve on the hospital board. There certainly will be an interaction far greater than was experienced in the past.
3. The new CEO will have much more authority because of the capacity to exercise authority and will be one of the main attributes a board search committee will now be seeking.
4. The individual will have to be much stronger in communication skills, both speaking and writing.

The American College of Hospital Administrators' (1984) study made the following suggestions: "Boards and medical staffs will look to CEOs for qualified evidence as they face critical decisions to initiate or expand profitability" (p. 90). This clearly reflects a growing and challenging interrelationship of activities and rapport between the board, medical staff, and CEO.

Holt (1986) studied the relationships between the self-reported leadership styles and conflict management techniques of a selected group of hospital middle management personnel. The results demonstrated that High Task and High Relationship was the dominant leadership style reported by the majority of respondents. The most frequently used supporting style was

that of High Relationship and Low Task. Respondents indicated compromise as their most frequently utilized mode of handling conflict. The second most frequently used technique was that of collaborating, although avoiding was used almost as frequently as collaborating.

McMurray (1987) determined whether a relationship exists between situational leadership effectiveness of administrators in hospitals and high schools in a selected geographical area. He found little or no relationship between effectiveness and respondents' age, number of employees reporting directly, monthly in-service/continuing education, and years of administrative experience.

According to the study conducted in 1990 by hospitals, 556 hospital CEOs nationwide said that the CEO best suited for the tasks is one with a "visionary" leadership style and a "decentralized" or "participatory" management style. In addition, these CEOs voted for the traditional CEO educational background (an MHA or an MBA with a health-care track) as being the best preparation for the top hospital job (Eubanks, 1990).

Griest and Belles (1990) revealed in their article that research was conducted by the Management Psychology Group in the area of leadership styles. The study looked at the personality characteristics of health care executives in comparison with a previously studied group of general business executives. It also looked at a number of motivational factors and lifestyle

characteristics of health care administrators. A total of 174 health care administrators participated in the study, 94% males and 6% females. The group averaged slightly over 40 years of age and were highly educated: 93% had completed graduate degrees. Most survey participants were senior administrators. The results showed that in comparison to their counterparts, the health care administrators appeared to be somewhat more introverted, focused, specialized, staff-oriented, and creative. The study also found that health care administrators are not particularly interested in managing and leading others. In fact, 27% of the health care administrators were drawn to health care management out of an interest in medicine, rather than out of an interest in management.

One way to attain knowledge about the practice of leadership of hospital administrators is to investigate styles and the effectiveness of these styles in current situations (Eubanks, 1990; Finnicks, 1984). Unfortunately, no study in this area has been conducted in Thailand. Therefore, this study was the first attempt to investigate the leadership styles, style flexibility, and style effectiveness of hospital administrators in Thailand.

### **Chapter Summary**

Four situational leadership models (1) Fiedler's (1967) Contingency theory, (2) House-Mitchell's (1971) path-goal theory, (3) Vroom and

Yetten's (1973) Normative model, and (4) Hersey and Blanchard's (1982) Situational Leadership model, were presented in this chapter. The framework of this study is represented by the Situational Leadership II model postulated by Blanchard et al. (1985) based on an interaction between directive behavior and supportive behavior. Four styles of leadership are identified in this model: directing, coaching, supporting, and delegating. Age, educational background, and years of experience in the current position (which were found to be popular variables in studying leadership behavior) were three demographic factors for this study. Numerous research studies have shown the inconsistencies and agreements regarding the relationship between these demographic factors and leadership styles.

## **CHAPTER III**

### **METHODOLOGY**

#### **Introduction**

This chapter consists of the following parts: (1) design of the study, (2) operational variables, (3) description of population and sample, (4) procedure, (5) description of the research instrument, (6) reliability and validity of the instrument, (7) statistical methodology, and (8) chapter summary.

#### **Design of the Study**

This study employed the survey research methodology to investigate the leadership styles, leadership style flexibility, and leadership style effectiveness in which a demographic information questionnaire and Leader Behavior Analysis II instrument were mailed to hospital administrators and their supervisors. The subjects were selected from Thai government general hospitals. The data collected were also used to examine the relationships of government-operated hospital administrators' leadership styles to each of the following demographic variables: age, educational background, and years of

experience in current position. The demographic information questionnaire (*see Appendix D*) was developed to determine personal information for each hospital administrator surveyed in terms of age, educational background, and years of experience in current position. The Leader Behavior Analysis II instrument which consists of LBA II-Self, LBA II-Other, and LBA II-Scoring developed by Blanchard et al. (1991a,b,c) were used to elicit descriptions of perceived leadership styles.

### **Operational Variables**

#### **Independent Variables**

The demographic variables were considered the independent variables of this study. The variables involved were: groups, age, educational background, and years of experience in current position. These variables were obtained from the demographic questionnaire.

Groups--The respondents' groups were classified into two groups according to their working status as: hospital administrator and supervisor.

Age--The administrators' age was classified into the following groups: 45 and under, 46-55, and over 55.

Educational background--The educational background of the administrators was classified into two categories: (1) educational background in medicine without any educational background in administrative area and

(2) educational background in medicine with some educational background in administrative area. The administrators who had only an educational background in medicine were labeled "medicine" and the ones who had both a medical degree and an educational background in administrative area were labeled "medicine plus administration."

Years of experience in current position--The administrators' years of experience in their current position were classified into three categories: 5 and under, 6-10, and over 10.

### **Dependent Variables**

Leadership styles, leadership style flexibility, and leadership style effectiveness as self-perceived and other-perceived, represented the dependent variable of this study. Leadership style flexibility refers to the degree to which the leader is able to vary his/her leadership styles through directing, coaching, supporting, and delegating styles of the Situational Leadership II theory (Zigarmi et al., 1991). Leadership Style Effectiveness refers to the ability of the leader to vary his/her leadership styles and the appropriateness of his/her behavior to each given situation in obtaining a desired outcome (Hersey & Blanchard, 1988).

For the purpose of this study, these variables were measured by using Blanchard et al. (1985) situational leadership II model and the Leadership Behavior Analysis II (LBA II-Self and LBA II-Other) (*see Appendix A & B*).

### **Description of Population and Sample**

In Thailand, there are 1,130 hospitals including government-operated and privately operated hospitals. Some hospitals consist of 500 to 1,000 beds (regional hospitals and medical centers), some consist of 150 to 500 beds (most general hospitals), and some just 10 to 60 beds (community hospitals) (*see Appendix G*). Each general hospital has a director as a hospital chief administrator. Each administrator is supervised by a Provincial Chief Medical Officer (PCMO) of each zone (Ministry of Public Health, Bangkok, Thailand, 1990). The whole population of the Thai government general hospital administrators and their supervisors were selected to be the population for this study. All were selected to participate in this study.

There are 65 general hospitals in Thailand, therefore the sample's size of the administrators is 65. The sample size for the supervisors is 59 since some supervisors oversee more than one hospital administrator. The name of the hospital administrators and their supervisors were taken from the list provided by the Thai National Health Care Association, Bangkok, Thailand



(Thai National Health Care Association, 1991). This list shows the names of all general hospital administrators and supervisors during the year 1991 (*see Appendix E & H*).

### Procedures

The LBA II--Self: Leader Behavior Analysis II and the LBA II--Other: Leader Behavior Analysis II which were developed by Blanchard et al. (1991a,b) (*see Appendix A & B*) were the main data collection instruments for this study.

A demographic information questionnaire (*see Appendix D*) was developed to determine personal information for each hospital administrator surveyed in terms of age, educational background, and years of experience in current position. This was attached to the LBA II-Self and/or the LBA II-Other instruments. Hospital administrators and their supervisors in the study were asked to respond to the demographic questionnaires along with the LBA II-Self and/or the LBA II-Other instruments.

A stamped self-addressed envelopes was enclosed in order to facilitate the return of both the instruments and the questionnaire. A letter of endorsement for the study issued by the Thai Ministry of Public Health was included in the packet with the instrument and the demographic information questionnaire in an effort to expedite responses. Included in every packet

was a personalized cover letter detailing the purpose of the study, the time frame for completion, and the procedure for anonymity. The letter carried an explanation that the code number at the bottom corner of the questionnaire was for the purpose of helping the researcher keep track of the surveyed materials as they were completed and returned, and of conducting a follow-up for non-respondents. Some packets were mailed to the hospital administrators and their supervisors and some were hand-delivered. The hospital administrators and their supervisors were asked to return the completed LBA II-Self and/or LBA II-Other instrument together with the demographic questionnaire by a certain date.

Immediately following the deadline, phone calls and/or personal visits were made to some of the supervisors and the hospital administrators' secretaries asking them to remind the non-responding supervisors and hospital administrators about the research study survey. Phone calls and/or personal visits were also made to some of the supervisors and the hospital administrators directly, asking them to complete the survey materials.

### **Description of the Research Instruments**

The purpose of this study was to investigate both self-perceived and other-perceived leadership styles. To accomplish this purpose, the LBA II--Self: Leader Behavior Analysis II and the LBA II--Other: Leader Behavior

Analysis II were used. Both instruments are available from the Center for Leadership Studies in Escondido, California (*see Appendix A & B*). These two instruments were chosen for the following reasons: first, because the instruments have been used widely since its introduction in the early 1970s. The authors of the instrument, Blanchard, Hambleton, Forsyth, and Zigarmi, enjoy reputations as authorities in leadership development (Martin, 1990; Zorn & Violanti, 1993). The second reason is that the instruments look at precisely the kind of leadership styles that most scholars currently hold to be the optimum: situational leadership (Bass, 1990; Martin, 1990; and Zorn & Violanti, 1993). The third reason is that the instruments have been used in other studies of Thai subjects in Thailand (see for example, the studies of Dhanasobhon in 1983 and Wisessang in 1988).

The Leader Behavior Analysis II has its roots in the work of Hersey and Blanchard (1982). Blanchard, Hambleton, Forsyth, and Zigarmi developed the Leader Behavior Analysis II according to the Situational Leadership theory (Zigarmi et al., 1991). Using the format of the existing LBA--the research instrument for Hersey and Blanchard's (1982) Situational Leadership--the authors wrote the LBA II in that same year. The LBA II is congruent with the changes in the model described by Blanchard et al. (1985). Several changes of the instruments were made consistent with repeated feedback from trainers and managers in the field. Efforts were

made to eliminate gender and race bias and the situations while remaining "generic" were refined to achieve as much business realism as possible. The major change from the LBA to the LBA II was made in the definition of Development Level (Zigarmi et al., 1991).

According to Situational Leadership II theory, leadership style is the combination of directive and supportive behaviors (Blanchard et al., 1987). The combination of directive and supportive managerial behavior is the basis for the four leadership styles (S1, S2, S3, S4) in the Situational Leadership II model:

S1 Directive: high directive and low supportive behavior

S2 Coaching: high directive and high supportive behavior

S3 Supporting: high supportive and low directive behavior

S4 Delegating: low supportive and low directive behavior.

Zigarmi et al. (1991) stated that Blanchard defines directive and supportive managerial behavior in the following way:

**Directive Behavior**--The extent to which the leader engages in one-way communication; spells out the follower(s)' role and tells the follower(s) what to do, where to do it, when to do it and how to do it; and then closely supervises performance. (p.3)

**Supportive Behavior**--The extent to which the leader engages in two-way communication, listens, provides support and encouragement, facilitates interaction and involves the follower(s) in decision making. (p. 3)

There are several manifestations of these definitions in the daily actions and work routines of most managers. The following is a list of directive behaviors as described by Zigarmi, Blanchard, and Zigarmi (1988):

1. Setting and Clarifying Goals
2. Planning Work in Advance for Subordinates
3. Setting Timeliness
4. Defining Roles
5. Defining Methods of Evaluation
6. Showing or Telling how a task or goal is to be done
7. Checking or Monitoring Work Progress. (p. 3)

Zigarmi et al., 1988 presented a list of supportive behaviors as follows:

1. Listening to the Subordinate (job or non-job related)
2. Praising
3. Asking for Input
4. Sharing Information about Total Organizations Operation

(Rationale)

5. Sharing Information about Self
6. Team Building
7. Mutual Problem Solving. (p. 3)

The above lists are not meant to be exhaustive, but rather illustrative of what is meant by the terms directive and supportive behaviors (Zigarmi et al., 1991). These behaviors and concepts are parallel to the classical definitions of structure and consideration or tasks and relationships as found in the models of Halpin (1969) and Fiedler (1967).

The four LBA II Style scores are the extended logical combinations of Directive and Supportive: (1) Style 1 = High Direction/Low Support, (2) Style 2 = High Direction/High Support, (3) Style 3 = High Support/Low Direction, and (4) Style 4 = Low Direction/ Low Support.

The Leader Behavior Analysis II consists of Leader Behavior Analysis II-Self (LBA II-Self), Leader Behavior Analysis II-Other (LBA II-Other), and Leader Behavior Analysis II-Scoring (LBA II-Scoring). It took 15 to 20 minutes to administer each instrument.

#### **Leader Behavior Analysis II-Self (LBA II-Self)**

LBA II-Self is designed to measure self-perceptions of three aspects of leadership behavior: leadership style, the flexibility of the leadership style, and the effectiveness of the leadership style (*see Appendix A*). The LBA II-Self is composed of 20 situations that involve the leader and one or more staff members. In each situation, there are four possible actions that a leader may choose. The leader assumes that he/she is the leader involved in each

of the 20 situations. Then he/she chooses one of the four leadership decisions. The choice of actions determines the leaders' leadership style: directing, coaching, supporting, or delegating. The respondent's leadership style is determined by adding the responses he/she makes for each of the items. The style which has the highest score or frequency is the primary leadership style (*see Appendix C*). For the purpose of this study the LBA II-Self was the instrument which each hospital administrator used to evaluate his/her own leadership styles, style flexibility, and style effectiveness. It provided an individual with feedback on his/her own leadership style.

#### **Leader Behavior Analysis II-Other (LBA II-Other)**

LBA II-Other is designed to measure other-perceptions of three aspects of leadership behavior: leadership style, the flexibility of the leadership style, and the effectiveness of the leadership style (*see Appendix B*). The instrument provides leaders with feedback on others' perception to their leadership style. It is composed of 20 situations that involve a leader and one or more staff members. In each situation, there are four possible actions that the supervisor may choose. The supervisor chooses one of the four leader decisions that he/she thinks would best describe the behavior of the leader in the situation presented. The choice of actions determines the leaders' leadership style: directing, coaching, supporting, or delegating.

The leadership style is determined by adding the responses a supervisor makes to each of the items. The style which has the highest score or frequency is the primary leadership style (*see Appendix C*). For the purpose of this study the LBA II-Other was the instrument which each supervisor used to evaluate the hospital administrators' leadership styles, style flexibility, and style effectiveness.

### **Leader Behavior Analysis II-Scoring (LBA II-Scoring)**

The LBA II-Self and the LBA II-Other have a scoring direction called "LBA II--Leader Behavior Analysis II: Scoring Directions" which was developed by Blanchard et al. (1991b) (*see Appendix C*). LBA II-Scoring is designed to tabulate and review the results of the LBA II-Self and LBA II-Other. Using the scoring sheet in the LBA II: Scoring Directions as a guideline, the scores are calculated, and the degree of a hospital administrator's leadership style flexibility and leadership style effectiveness are determined.

According to LBA II-Scoring, the style flexibility refers to the degree to which a hospital administrator is able to vary his/her leadership style through directing, coaching, supporting, and delegating. The style flexibility scores range from 0-30. A score closer to 0 indicates low style flexibility. A low score is obtained when the respondent selects the same one or two



styles for most of the situations described in the LBA II-Self instrument. A score closer to 30, indicating high style flexibility, is obtained when the respondent uses each of the four styles a number of times.

The leadership style effectiveness refers to the ability of a hospital administrator to vary his/her leadership styles appropriately to a given situation in order to obtain a desired outcome. Style effectiveness scores range from 20-80. A score closer to 20, indicating low style effectiveness, is obtained when the respondent chooses a number of fair or poor leadership style choices for the 20 situations in the instrument. A score closer to 80, suggesting high style effectiveness, is obtained when the respondent chooses mostly good and excellent leadership style choices.

### **The Demographic Information Questionnaire**

The demographic information questionnaire was developed by this investigator to describe the various backgrounds of the hospital administrators (*see Appendix D*). The demographic portion of the questionnaire provided data on the hospital administrators' (1) age, (2) educational background, and (3) years of experience in the current position.

### **Reliability and Validity of the Instruments**

According to Zigarmi et al. (1991), the Situational Leadership model was revised in 1984-85. Several changes of the instruments were made consistent with repeated feedback from trainers and managers in the field. Zigarmi et al. (1991) also added that efforts were made to eliminate gender and race bias; and the situations, while remaining "generic," were refined to achieve as much business realism as possible.

Zigarmi et al. (1991) reported that various reliability studies have been conducted on the LBA and the LBA II forms during the past 8 years. The coefficients were quite stable over time and across the various groups. "In general the internal consistencies on the LBA II-Other are extremely good (ranging from a low of .54 to a high of .86). The internal consistencies for the Self are adequate for self-report instruments (ranging from a low of .43 to a high of .60)" (p. 87). Alpha coefficients are reported as shown in Table 1.

TABLE 1  
INTERNAL CONSISTENCY RELIABILITY FINDINGS FOR  
LBA, LBA II-SELF, AND LBA II-OTHER

Source	Year	Style	S1	S2	S3	S4	N
Edeburn and Zigarmi	1982	LBA	.81	.60	.71	.84	1462
Edeburn and Zigarmi	1983	LBA	.83	.60	.68	.85	806
Haley	1983	LBA	.83	.62	.69	.84	1,015
Clothier	1984	LBAlI-Other	.86	.70	.77	.82	123
Edeburn and Zigarmi	1989	LBAlI-Self	.51	.45	.56	.42	116
Edeburn and Zigarmi	1989	LBAlI-Other	.76	.54	.74	.84	463
Edeburn and Zigarmi	1990	LBAlI-Self	.57	.29	.41	.64	46
Edeburn and Zigarmi	1990	LBAlI-Other	.62	.61	.70	.82	254
Edeburn and Zigarmi	1990	LBAlI-Self	.40	.55	.62	.51	57
Edeburn and Zigarmi	1990	LBAlI-Other	.76	.57	.75	.80	396

Note: This data was compiled from Research on the LBA II: A Validity and Reliability Study, (pp. 79, 81, 86), by Zigarmi, D., Edeburn, C., and Blanchard, K., 1991, Blanchard Training and Development.

### Statistical Methodology

The returned responses of the LBA II-Self and the LBA II-Other instruments were scored by the researcher on the scoring sheets according to the guidelines proposed in the LBA II: Scoring Directions (Blanchard et al., 1991c) (*see Appendix C*). The Statistical Analysis System (SAS) (Statistical Analysis System Incorporated, 1990) was used for data analysis. The data were processed, coded, and entered into the computer at Andrews University for this purpose. The following research questions were examined:

As measured by the LBA II-Self and the LBA II-Other instruments,

1. What is the primary self-perceived leadership style of Thai government hospital administrators?
2. What is the primary leadership style of Thai government hospital administrators as perceived by their supervisors?
3. What is the relationship between self-perceived leadership styles, leadership flexibility, and leadership effectiveness; and supervisor-perceived primary leadership style, leadership flexibility, and leadership effectiveness of the Thai government hospital administrators?
4. What is the relationship between the primary leadership style, leadership flexibility, and leadership effectiveness of the government hospital administrators in Thailand and age, educational background, and years of experience in current position?

The following hypotheses were examined:

1. There is a significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership style of Thai government hospital administrators.
2. There is a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.
3. There is a significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.
4. There is a significant relationship between the primary leadership style of the Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.
5. There is a significant relationship between the flexibility of the leadership style of Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.
6. There is a significant relationship between the effectiveness of the leadership style of Thai government hospital administrators (as perceived by

others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.

The basic source used to answer research questions 1, 2, and 3 was the LBA II-Self and the LBA II-Other instruments. The returned responses of the LBA II-Self and the LBA II-Other instruments were scored by the researcher on the scoring sheets according to the guidelines proposed in the LBA II: Scoring Directions (Blanchard et al., 1991c) (*see Appendix A, B, & C*). The basic source used to answer research questions 4 was the LBA II-Other instruments, the LBA II-Scoring, and the demographic questionnaire (*see Appendix B, C, & D*).

The null hypotheses to be tested are:

1. There is no significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership style of Thai government hospital administrators.
2. There is no significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.
3. There is no significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.

4. There is no significant relationship between the primary leadership style of the Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.

5. There is no significant relationship between the flexibility of the leadership style of Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.

6. There is no significant relationship between the effectiveness of the leadership style of Thai government hospital administrators (as perceived by others) and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.

Chi-Square is one of the best-known tests of statistical significance, it is easy to understand and calculate. It is a very popular form of hypothesis testing and it makes so few assumptions about the underlying population that it is commonly classified as a nonparametric test (Ferguson & Tahane, 1989). Chi-Square is appropriate to examine the relationship between nominal variables in the population and tests whether any apparent relationship in the sample is due to chance (Weisberg & Bowen, 1977).

Since Chi-Square provides a simple test based on the difference between observed and expected frequencies, the researcher employed

Chi-Square Analysis to determine whether there was a relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership styles of hospital administrators and whether there was relationship between the primary leadership style of the hospital administrators and the following demographic variables: (a) age, (b) educational background, (c) years of experience in the current position.

The dependent-t is used for testing the hypotheses when the data are correlated. The data are considered correlated if a subject scoring high under one condition tends to score relatively high under the second condition as well, and vice versa. That is, the scores under one condition are positively and strongly correlated on the scores in the other condition (Hinkle, Wiersma, & Jurs, 1988). In this study, self-perceived scores and supervisors-perceived scores were correlated since both viewed the same subjects (hospital administrators). Thus, the dependent-t was used for testing hypotheses 2 and 3 in order to determine whether there was a significant difference between self-perceived and supervisor-perceived leadership flexibility of hospital administrators. This analysis was also used to determine whether there was a significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.



When sample size is small and a researcher has to use the sample standard deviation to estimate the population standard deviation, the sampling distribution to use is  $t$  distribution with  $N-1$  degrees of freedom (Loether & McTavish, 1980). The difference between two population means is appropriately examined by using the  $t$ -test (Mendenhall, 1987). Thus, it was appropriate to use  $t$ -test to determine whether there was a significance relationship between the leadership flexibility and educational background since the sample size was small and it was the testing of the difference between two population means (Mendenhall, 1987; Wonnacott & Wonnacott, 1984). The analysis of  $t$ -test was also used to determine whether there was a significance relationship between the leadership effectiveness and educational background for the same reason as indicated above.

Pearson's correlation coefficients indicates the proportion of the variation in one variable which is explained by its linear association with the other variable (Loether & McTavish, 1980). In other words, its square describes the nature of the relationship between two interval variables so as to predict the dependent variable. Therefore, Pearson's correlation coefficients was used to test whether there is a significant relationship between the flexibility of the leadership style of hospital administrators and the demographic variables: age and years of experience in the current position. This analysis also used to test whether there is a significant

relationship between the effectiveness of the leadership style of hospital administrators and the demographic variables: age and years of experience in the current position.

An alpha level of .05 was set for the rejection of the null hypotheses. The contingency tables were provided in order to make it possible to determine the significance of the differences.

### **Chapter Summary**

The sample for this study consists of hospital administrators of government-operated general hospitals in Thailand. The basic source of the hospital administrators' leadership styles, style flexibility, and style effectiveness was provided by the LBA II-Self and the LBA II-Other instruments. Information presented in this chapter included a design of the study, the operational variables, a description of population and sample, the procedure, a description of the research instrument, the reliability and validity of the instruments, the data collection, and appropriate statistical methods utilized. The data were analyzed by using descriptive statistics--Chi-Square, Dependent-t, T-test, and Pearson's correlation coefficients. The findings are presented in chapter 4 in relation to each of the three major areas: leadership style, leadership style flexibility, and leadership style effectiveness.

## **CHAPTER IV**

### **PRESENTATION AND ANALYSIS OF DATA**

#### **Introduction**

This chapter contains an analysis of the data collected from the hospital administrators and their supervisors in Thailand. This research was designed to investigate leadership styles, style flexibility, and the style effectiveness of the hospital administrators as perceived by themselves and by their supervisors. It was also designed to describe the relationship of hospital administrators' primary leadership styles, style flexibility, and style effectiveness as perceived by their supervisors to each of the following demographic variables: age, educational background, and years of experience in current position. The results of the study are presented under the following headings: (1) a general demographic description of the hospital administrators, (2) primary leadership styles, (3) leadership style flexibility, (4) leadership style effectiveness, (5) primary leadership style, leadership style flexibility, leadership style effectiveness, and demographic variables.

### **A General Demographic Description of the Hospital Administrators**

One hundred and one hospital administrators and their supervisors, or 78.29% of those surveyed in Thailand, participated in this study. Fifty-four of the respondents were hospital administrators and forty-seven were supervisors. The demographic information about these administrators--age, educational background, and years of experience in current position--was shown in Table 2.

As demonstrated in Table 2, 1 female and 53 male hospital administrators participated in the study. The administrators' age was classified into the following groups: 45 and under, 46-55, and over 55. The greatest number (25 or 46.30%) of administrators was in the age of over 55, whereas the smallest number (13 or 24.07%) of administrators was in the 45 and under group. Sixteen administrators (29.23%) were in the age range of 46-55.

Based on the criteria created for this study, the educational background was classified into two categories: (1) educational background in medicine without any educational background in administrative area and (2) educational background in medicine with some educational background in administrative area (*see Table 2*). The administrators who had only an educational background in medicine were labeled "medicine" and the ones who had both a medical degree and an educational background in

TABLE 2  
FREQUENCIES FOR DEMOGRAPHIC INFORMATION  
FOR HOSPITAL ADMINISTRATORS

Demographic Variables	n <sup>a</sup>	Percentage
Gender		
Male	53	98.15
female	1	1.85
Age		
45 & Under	13	24.07
46 - 55	16	29.23
Over 55	25	46.30
Educational Background		
Medicine	46	85.19
Medicine plus Administration	8	4.81
Years in Current Position		
5 & Under	32	59.26
6 - 10	13	24.07
Over 10	9	16.66

<sup>a</sup>n = 54

administrative area were labeled "medicine plus administration." As shown in Table 2, the majority (46 or 85.19%) of the administrators were in the "medicine" category. The remainders (8 or 14.81%) had an educational background in "medicine plus administration."

The administrators' years of experience in their current position were classified into three categories: 5 and under, 6-10, and over 10. As shown in Table 2, the greatest number (32 or 59.26%) of the administrators had 5 years or less experience in their current position, whereas the smallest number (9 or 16.66%) of administrators had over 10 years experience. Thirteen or 24.07% of the administrators had 6-10 years of experience in their current position.

The majority of the administrators were over 55 years of age, possessed an educational background in the area of medicine without any extra education in the area of administration, and had 5 years or less experience in their current position.

Table 3 shows the demographic information of the supervisors. The demographic information were categorized and classified the same way as of the demographic information of the hospital administrators. The majority of the supervisors were 46 to 55 years of age, possessed an educational background in the area of medicine with extra education in administration, and had 5 years or less experience in their current position.

TABLE 3  
FREQUENCIES FOR DEMOGRAPHIC INFORMATION  
FOR SUPERVISORS

Demographic Variables	n <sup>a</sup>	Percentage
Gender		
Male	47	100.00
Female	-	-
Age		
45 & Under	17	36.17
46 - 55	21	44.68
Over 55	9	19.15
Educational Background		
Medicine	21	44.68
Medicine plus Administration	26	55.32
Years of experience in Current Position		
5 & Under	23	48.94
6 - 10	14	29.79
Over 10	10	21.28

<sup>a</sup>n = 47

## Primary Leadership Style

### Research Question 1

Research question 1 asked: What is the primary self-perceived leadership style of Thai government hospital administrators?

Data obtained from the LBA II-Self instrument and the demographic information questionnaire provided the information necessary to answer research question 1.

Table 4 shows the frequencies and percentages of the various leadership styles of hospital administrators as they themselves perceived them. Using the scoring scheme of the LBA II-Self, four leadership styles (S1, S2, S3, and S4) may be obtained. The primary leadership style is determined by the highest score of the four possible styles. For example, if a person scores 4 for S1, 2 for S2, 6 for S3 and 8 for S4, then that person's primary leadership style is S4 which is low supportive and low directive (*see Appendix C*). If the highest score for any administrators was the same for more than one leadership style, his/her primary leadership styles were labeled by those styles in a separate category.



TABLE 4

PRIMARY LEADERSHIP STYLES OF HOSPITAL ADMINISTRATORS  
IN THAILAND AS PERCEIVED BY THEMSELVES

Leadership Styles*	n	Percentage
S3	35	64.81
S2	9	16.67
S4	1	1.85
S1 & S3	3	5.56
S2 & S3	3	5.56
S3 & S4	2	3.70
S1 & S2 & S3	1	1.85
Total	54	100.00

\*S1: Directing (high directive, low supportive behavior)

S2: Coaching (high directive, high supportive behavior)

S3: Supporting (high supportive, low directive behavior)

S4: Delegating (low supportive, low directive behavior)

S1 & S3, S2 & S3, S3 & S4, and S1 & S2 & S3: Primary leadership styles

The majority (64.81 %) of the administrators had S3 or the "supporting" style of high supportive and low directive behavior as their primary leadership style. There was no administrator who had S1 or the "directing" style. Nine (16.67%) had S2 or the "coaching" style of high directive and high supportive behavior. The remainder had S4 or the "delegating" style of low supportive and low directive behavior. There were 8 administrators who had two primary leadership styles: 3 administrators (5.56%) with S1 and S3 or "directing and supporting," 3 administrators (5.56%) with S2 and S3 or "coaching and supporting" as the primary

leadership styles; and 2 administrators (3.70%) with S3 and S4 or "supporting and delegating." That is, their highest scores or frequencies were identical in both of the two leadership styles. One administrator (1.85%) exhibited three primary leadership styles. That is, his highest scores or frequencies were identical in three leadership styles (*see Table 4*).

In summary, the "supporting style" (S3) of high supportive and low directive was the primary leadership style of the majority of the hospital administrators according to self-perceived. That is, these leaders facilitate and support followers' efforts toward task accomplishment and share responsibility for decision-making with them.

## **Research Question 2**

Research question 2 asked: What is the primary leadership style of Thai government hospital administrators as perceived by their supervisors?

Data obtained from the LBA II-Other instrument and the demographic information questionnaire provided the information necessary to answer Research Question 2.

Table 5 shows the frequencies and percentages of the administrators utilizing their primary leadership styles as perceived by their supervisors. Using the scoring scheme as with the hospital administrators, the following results were obtained.

TABLE 5

PRIMARY LEADERSHIP STYLES OF HOSPITAL ADMINISTRATORS  
AS PERCEIVED BY THEIR SUPERVISORS

Leadership Styles* Percentage	<u>n</u>	
S3	25	53.19
S2	8	17.02
S1	2	4.26
S4	3	6.38
S1 & S3	1	2.13
S2 & S3	7	14.89
S3 & S4	1	2.13
Total	47	100.00

\*S1: Directing (high directive, low supportive behavior)

S2: Coaching (high directive, high supportive behavior)

S3: Supporting (high supportive, low directive behavior)

S4: Delegating (low supportive, low directive behavior)

S1 & S3, S2 & S3, S3 & S4, and S1 & S2 & S3: Primary leadership styles

As indicated in Table 5, the majority (53.19%) of the administrators were perceived as using S3 or the "supporting" style of high supportive and low directive behavior as their primary leadership style. There were two (4.26%) administrators who were perceived as using S1 or the "directing" style and eight (17.02%) as using S2 or the "coaching" style of high directive and high supportive behavior. The remainder were perceived as using S4 or the "delegating" style of low supportive and low directive behavior and nine administrators as using two primary leadership styles:

1 administrator (2.13%) with S1 and S3 or "directing and supporting" style, another with S3 and S4 or "supporting and delegating," and seven (14.89%) administrators with S2 and S3 or "coaching and supporting."

In summary, the "supporting style" (S3) of high supportive and low directive was perceived as the primary leadership style of the majority of the hospital administrators. That is, their supervisors saw that these leaders facilitate and support followers' efforts toward task accomplishment and share responsibility for decision-making with them.

### **Research Question 3**

Research question 3 asked: What is the relationship between self-perceived leadership styles, leadership flexibility, and leadership effectiveness; and supervisor-perceived primary leadership style, leadership flexibility, and leadership effectiveness of the Thai government hospital administrators?

### **Hypothesis 1**

Hypothesis 1 states: There is a significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership style of Thai government hospital administrators.

The Chi-Square test was used to determine if there was a significant relationship between self-perceived primary leadership styles and supervisor-

perceived primary leadership styles of Thai government hospital administrators as measured by the LBA II-Self and LBA II-Other instruments at the .05 level of significance. For the purpose of this study, it was necessary to combine frequencies of other primary leadership styles which are not "supporting" (S3) because too many expected frequencies lower than 5 for cells in a contingency table violates the Chi-Square test assumption. Thus, all frequencies in other primary leadership styles were combined into one category except S3 in order to strengthen the Chi-Square analysis (Ferguson & Tahane, 1989).

Table 6 shows the Chi-Square Analysis for this hypothesis. At .05 level of significance with 1 degree of freedom, the probability  $p$  was 0.007 and thus, did not exceed .05 level of significance; consequently, the null hypothesis was rejected. There was a significant relationship between self-perceived and supervisor-perceived primary leadership styles of Thai government hospital administrators. As indicated in Table 6, approximately 76% of supervisors and administrators agreed that hospital administrators used the "supporting" style (S3). That is, they agreed that the hospital administrators used the "supporting" style of high supportive, low directive behavior more than other leadership styles. Only 28% (11 out of 39) of supervisors and administrators disagreed.

TABLE 6

CHI-SQUARE ANALYSIS OF RELATIONSHIP BETWEEN SELF-  
PERCEIVED AND SUPERVISOR-PERCEIVED LEADERSHIP  
STYLE OF HOSPITAL ADMINISTRATORS

Supervisors		Administrators		
		Self-perceived		
		S3	S*	Total
Supervisor-perceived	S3	16 (76.19%)	5 (23.81%)	21
	S*	6 (33.33%)	12 (66.67%)	18
	Total	22	17	39
Chi-Square	DF=1	Value=7.240	Prob=0.007	

\* is the sum of the rest  
of the primary leadership styles which are not S3.

Note: While the sample size of hospital administrators and supervisors are 54 and 47 respectively, the sample size for this analysis is 39 which are the matched pairs of hospital administrators and their supervisors.

### **Leadership Style Flexibility**

Leadership style flexibility refers to the degree to which an administrator is able to vary his/her leadership style through directing, coaching, supporting, and delegating. The style flexibility scores range from 0 to 30. A score closer to 0, indicating low style flexibility, is obtained when the administrator or their supervisor select the same one or two styles for most of the situations in the LBA II-Self and the LBA II-Other instruments. A score closer to 30, suggesting high style flexibility, is obtained when he/she used each of the four styles a number of times.

### **Research Question 3**

Research question 3 asked: What is the relationship between self-perceived leadership styles, leadership flexibility, and leadership effectiveness; and supervisor-perceived primary leadership style, leadership flexibility, and leadership effectiveness of the Thai government hospital administrators?

### **Hypothesis 2**

Hypothesis 2 states: There is a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.

The dependent-t was used to determine if there was a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators as measured by the LBA II-Self and LBA II-Other instruments.

Table 7 shows the means and the standard deviations of the style flexibility scores as perceived by the hospital administrators themselves and their supervisors. The mean self-perceived flexibility score was 22.31. The mean supervisors-perceived flexibility score was 19.28. These scores indicated that both the administrators and their supervisors perceived that the administrators possessed a moderate degree of flexibility in utilizing their leadership styles. There was a slight difference between those two means--the self-perceived score was greater than the supervisors-perceived score. That is, the administrators saw themselves as more flexible in utilizing different leadership styles.

Table 7 also shows the dependent-t values for answering hypothesis 2. At the .05 level of significance, with 99 degrees of freedom, the probability  $p$  was 0.002 and thus, did not exceed .05; consequently, the null hypothesis was rejected. There is a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.



TABLE 7  
MEANS, STANDARD DEVIATIONS, AND DEPENDENT-T FOR  
SELF-PERCEIVED AND SUPERVISOR-PERCEIVED  
LEADERSHIP STYLE FLEXIBILITY

Administrators (N=39)		Supervisors (N=39)	
Mean	Std	Mean	Std
22.31	3.57	19.28	3.53

Mean difference = 3.026

Std Error = 0.887

T = 3.410

Prob = 0.002

\* is the mean difference between hospital administrators-perceived and supervisors-perceived. While the sample size of hospital administrators and supervisors are 54 and 47 respectively, the sample size for this analysis is 39 which are the matched pairs of hospital administrators and their supervisors.

$p < 0.05$

### **Leadership Style Effectiveness**

Leadership style effectiveness refers to the ability of the administrator to vary his/her leadership styles appropriately to the given situation in obtaining desired outcomes. Style effectiveness scores range 20-80. A score closer to 20, indicating low style effectiveness, is obtained when the administrator chooses a number of fair or poor leadership style choices for the 20 situations in the LBA II-Self instrument. A score closer to 80, suggesting high style effectiveness, is obtained when the administrator chooses mostly good and excellent leadership style choices.

### **Research Question 3**

Research question 3 asked: What is the relationship between self-perceived leadership styles, leadership flexibility, and leadership effectiveness; and supervisor-perceived primary leadership style, leadership flexibility, and leadership effectiveness of the Thai government hospital administrators?

### **Hypothesis 3**

Hypothesis 3 states: There is a significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.

The dependent-t was used to determine if there was a significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators as measured by the LBA II-Self and LBA II-Other instruments.

Table 8 contains the means and the standard deviations of the style effectiveness scores as perceived by the hospital administrators themselves and their supervisors. The mean self-perceived effectiveness score was 48.56. The mean supervisors-perceived effectiveness score was 49.92. These scores indicated that both the administrators and their supervisors perceived that the administrators possessed a moderate degree of effectiveness in utilizing their leadership styles.

At the .05 level of significance, with 99 degrees of freedom, the probability  $p$  was 0.261, and thus, exceeded the .05 level of significance; consequently, the null hypothesis was retained. There was no significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.

TABLE 8  
MEANS, STANDARD DEVIATIONS, AND  
DEPENDENT-T FOR SELF-PERCEIVED AND  
SUPERVISOR-PERCEIVED LEADERSHIP  
STYLE EFFECTIVENESS

Administrators (N=39)		Supervisors (N=39)	
Mean	Std	Mean	Std
48.56	5.70	49.92	5.44

Mean difference = -1.359

Std Error = 1.190

T = -1.142

Prob = 0.261

\* is the mean difference between hospital administrators-perceived and supervisors-perceived. While the sample size of hospital administrators and supervisors are 54 and 47 respectively, the sample size for this analysis is 39 which is the match pairs of hospital administrators and their supervisors.

$p < 0.05$

**Primary Leadership Style, Leadership Style  
Flexibility, Leadership Style Effectiveness,  
and Demographic Variables**

Blanchard et al. (1985) stated: "Self-perception of how the leader behaves is interesting but it tells the leader only how he/she intend to act. Unless it matches the perceptions of others it is not very helpful" (p. 20). In order to illustrate the above thought it should be mentioned that Hersey and Blanchard (1988) defined leadership style as follows:

The leadership style of an individual is the behavior pattern that a person exhibits when attempting to influence the activities of others as perceived by those others. This may be very different from the leader's perception, which we shall define as self-perception rather than style. (p. 116)

Thus, for the study in this section, the others' perceived (supervisor-perceived) primary leadership style, leadership style flexibility, and leadership style effectiveness was used to define the leadership style of hospital administrators.

**Primary Leadership Style and Demographic  
Variables**

**Research Question 4**

Research question 4 asked: What is the relationship between the primary leadership style, leadership flexibility, and leadership effectiveness of the government hospital administrators in Thailand and age, educational background, and years of experience in current position?

#### Hypothesis 4

Hypothesis 4 states: There is a significant relationship between the primary leadership style of the Thai government hospital administrators and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.

The Chi-Square test was used to determine if there was a significant relationship between hospital administrators' primary leadership styles, group, age, educational background, and years of experience in current position at the .05 level of significance. For the purpose of this study, it was necessary to combine frequencies of other primary leadership styles which are not "supporting" (S3) because too many expected frequencies lower than 5 for cells in a contingency table violates the Chi-Square test assumption. Therefore, all frequencies in other primary leadership styles were combined into one category except S3 in order to strengthen the Chi-Square analysis.

Chi-Square explains the relationships between the primary leadership styles of hospital administrators and their age (*See Table 9*). At .05 level of significance, with 2 degrees of freedom, the probability  $p$  was 0.41 and thus, exceeded the .05 level of significance. This means there was no statistically significant relationship between the primary leadership style of the government hospital administrators in Thailand and these following age groups: 45 years and under, 46-55 years, and over 55 years.

TABLE 9  
RELATIONSHIPS BETWEEN THE PRIMARY LEADERSHIP  
STYLES OF HOSPITAL ADMINISTRATORS AND AGE  
AS PERCEIVED BY SUPERVISORS

Group	S3	S*	Total
Age 45 and under	10 (58.82%)	7 (41.18%)	17
Age 46-55	12 (57.14%)	9 (42.86%)	21
Age over 55	3 (33.33%)	6 (66.67%)	9
Total	25	22	47
Chi-Square    DF=2    Value=1.77    Prob=0.41			
Sample Size = 47			

\*S is the sum of the rest of the primary leadership styles which are not S3.

Table 10 shows Chi-Square Analysis explaining the relationships between the primary leadership styles of hospital administrators and their educational background. At .05 level of significance, with 1 degree of freedom, the probability  $p$  was 0.49 and exceeded the .05 level of significance. This means there was no statistically significant relationship between the primary leadership style of the government hospital administrators in Thailand and those who possessed a medical degree and those who possessed a medical degree plus a degree in administration.

TABLE 10

RELATIONSHIPS BETWEEN THE PRIMARY LEADERSHIP STYLES  
OF HOSPITAL ADMINISTRATORS AND EDUCATIONAL  
BACKGROUND AS PERCEIVED BY SUPERVISORS

Group	S3	S*	Total
Medical	10 (47.62%)	11 (52.38%)	21
Medical plus administration	15 (57.69%)	11 (42.31%)	26
Total	25	22	47
Chi-Square    DF=1    Value=0.47    Prob=0.49			
Sample Size = 47			

\*S is the sum of the rest of the primary leadership styles which are not S3.



Table 11 shows Chi-Square Analysis explaining the relationships between the primary leadership styles of hospital administrators and their years of experience in current position. At .05 level of significance, with 2 degrees of freedom, the probability  $p$  was 0.55 and thus, exceeded the .05 level of significance. This means there was also no statistically significant

TABLE 11

RELATIONSHIPS BETWEEN THE PRIMARY LEADERSHIP  
STYLES OF HOSPITAL ADMINISTRATORS AND YEARS  
OF EXPERIENCE IN CURRENT POSITION AS  
PERCEIVED BY SUPERVISORS

Group	S3	S*	Total
5 and under	14 (60.87%)	9 (39.13%)	23
6-10	6 (42.86%)	8 (57.14%)	14
Over 10	5 (50.00%)	5 (50.00%)	10
Total	25	22	47

Chi-Square    DF=2    Value=1.19    Prob=0.55

Sample Size = 47

\*S is the sum of the rest of the primary leadership styles which are not S3.

relationship between the primary leadership style of the government hospital administrators who were different in years of experience in current position: 5 years and less, 6-10 years, and over 15 years.

In summary, the null hypothesis--There was no significant relationship between the primary leadership style of the government hospital administrators in Thailand and age, educational background, and years of experience in current position--was retained as explained above.

### **Leadership Style Flexibility and Demographic Variables**

#### **Research Question 4**

Research question 4 asked: What is the relationship between the primary leadership style, leadership flexibility, and leadership effectiveness of the government hospital administrators in Thailand and age, educational background, and years of experience in current position?

#### **Hypothesis 5**

Hypothesis 5 states: There is a significant relationship between the flexibility of the leadership style of Thai government hospital administrators and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.

Table 12 contains the means and the standard deviations of the style flexibility scores, age, and years of experience as perceived by the supervisors. The means were 19.36, 47.94, and 7.36, respectively. The standard deviations were 3.47, 6.83, and 6.73, respectively.

TABLE 12

PEARSON'S CORRELATION COEFFICIENTS SHOWING THE  
RELATIONSHIP OF ADMINISTRATORS' FLEXIBILITY  
SCORE\* TO VARIOUS DEMOGRAPHIC VARIABLES

	Mean	<u>Std</u> <u>Dev.</u>	Flexibility score	Age	Years of Experience
Flexibility Score	19.36	3.47		$r=0.23$	$r=0.10$
Age	47.94	6.83			0.33
Years of Experience	7.36	6.73			

\*as perceived by supervisors

Using the Pearson's correlation coefficients, an analysis was done on the relationship between the flexibility scores of the responding supervisors ( $n=47$ ) and the following variables: age and years of experience in current position.

The correlation coefficient between the flexibility scores and age was 0.23. The correlation coefficient between the flexibility scores and years of

experience in current position was 0.10. This shows little correlation between flexibility scores and age and years of experience in current position. None of these correlation coefficients are significant at the 0.05 level (*See Table 12*).

Table 13 shows the  $t$  test values for answering this hypothesis: if a significant relationship exists between the flexibility of the leadership style of Thai government hospital administrators as perceived by supervisors and educational background. At the .05 level of significance, with 45 degrees of freedom, the probability  $p$  was 0.38 and thus, exceeded the .05 level of significance; consequently, the null hypothesis was retained. There is no significant difference between the leadership flexibility scores of Thai government hospital administrators who possessed different educational background: medical and medical plus administration.

In summary, the null hypothesis--There was no significant relationship between the flexibility of the leadership style of the government hospital administrators in Thailand and age, educational background, and years of experience in current position--was retained as explained above.

TABLE 13

T-TEST SHOWING THE RELATIONSHIP  
OF STYLE FLEXIBILITY SCORES\* AND  
EDUCATIONAL BACKGROUND

Educational Background		N	Mean	Std Dev.
Medical		21	18.86	4.08
Medical plus administration		26	19.77	2.90
T-test	DF=45	T=-0.89	Prob=0.38	

\*as perceived by supervisors

### Leadership Style Effectiveness and Demographic Variables

#### Research Question 4

Research question 4 asked: What is the relationship between the primary leadership style, leadership flexibility, and leadership effectiveness of the government hospital administrators in Thailand and age, educational background, and years of experience in current position?

#### Hypothesis 6

Hypothesis 6 states: There is a significant relationship between the effectiveness of the leadership style of Thai government hospital

administrators and the following demographic variables: (a) age, (b) educational background, and (c) years of experience in the current position.

Table 14 contains the means and the standard deviations of the style effectiveness scores, age, and years of experience as perceived by the supervisors. The means were 49.72, 47.94, and 7.36, respectively. The standard deviations were 3.47, 6.83, and 6.73, respectively.

TABLE 14  
PEARSON'S CORRELATION COEFFICIENTS SHOWING THE  
RELATIONSHIP OF ADMINISTRATORS' EFFECTIVENESS  
SCORE\* TO VARIOUS DEMOGRAPHIC VARIABLES

	Mean	<u>Std</u> <u>Dev.</u>	Effectiveness score	Age	Years of Experience
Effectiveness Score	49.72	3.47		$r=0.02$	$r=0.05$
Age	47.94	6.83			0.33
Years of Experience	7.36	6.73			

\*as perceived by supervisors

Using the Pearson's correlation coefficient, an analysis was done on the relationship between the effectiveness scores of the responding supervisors ( $n=47$ ) and the following variables: age and years of experience in current position.

Table 14 depicts the results of the correlation analysis. The correlation coefficient between the effectiveness scores and age was 0.02. The correlation coefficient between the effectiveness scores and years of experience in current position was 0.05. Neither of these correlation coefficients is significant at the 0.05 level. Therefore, it was concluded that there were no correlations between leadership effectiveness scores and age and years of experience in current position of hospital administrators.

Table 15 gives the  $t$  test values for answering hypothesis 6--if a significant relationship exists between the effectiveness of the leadership style of Thai government hospital administrators and educational background. At the .05 level of significance with 45 degrees of freedom, the probability  $p$  was 0.38, and thus, exceeded the .05 level of significance; consequently the null hypothesis was retained. There is no significant difference between the hospital administrators' leadership effectiveness scores of hospital administrators with medical degrees only and those with medical plus administration degrees.

In summary, the null hypothesis--There was no significant relationship between the effectiveness of the leadership style of the government hospital administrators in Thailand and age, educational background, and years of experience in current position--was retained as explained above.

TABLE 15

T-TEST SHOWING THE RELATIONSHIP OF  
STYLE EFFECTIVENESS SCORES\* AND  
EDUCATIONAL BACKGROUND

Educational Background	N	Mean	Std Dev
Medical	21	49.14	3.81
Medical plus administration	26	50.19	5.92
T-test	DF=45	T=-0.89	Prob=0.38

\*as perceived by supervisors

### Chapter Summary

The statistical approach used to answer the research questions and to test the research hypotheses was the Chi-Square, dependent-t,  $t$  test, and Pearson's correlations coefficients. The findings of this study showed that the "supporting style" (S3) of high supportive and low directive was the primary leadership style of the majority of the hospital administrators as perceived by both hospital administrators and their supervisors. That is, these leaders facilitate and support followers' efforts toward task accomplishment and share responsibility for decision-making with them.

In addition, these followings were found: (1) both the hospital administrators and their supervisors perceived that the administrators



possessed a moderate degree of flexibility in utilizing their leadership styles, (2) the administrators saw themselves as more flexible in utilizing different leadership styles than their supervisors did, and (3) both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of effectiveness in their leadership styles.

An analysis of data also showed that:

1. There was a significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership styles of Thai government hospital administrators.
2. There was a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.
3. There was no significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.
4. The relationship between hospital administrators' primary leadership styles as perceived by supervisors and their age, educational background, and years of experience in current position was not statistically significant.

5. The relationship between hospital administrators' leadership style flexibility as perceived by supervisors and age, educational background, and years of experience in current position was not statistically significant.

6. The relationships between hospital administrators' leadership style effectiveness as perceived by supervisors and their age, educational background, and years of experience in current position were not statistically significant.

## **CHAPTER V**

### **SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS**

#### **Introduction**

This chapter contains a summary of the present study, the conclusions developed from the results of the study, and recommendations for practice and further study.

#### **Summary of the Study**

This study used a descriptive design to study the leadership styles, primary leadership style, style flexibility, and style effectiveness of hospital administrators as self-perceived and as perceived by their supervisors. The purpose also was to examine what relationships these hospital administrators had with selected demographic variables--age, educational background, and years of experience in current position. This study was conducted in the hope that it might help hospital administrators gain insight into their own leadership styles, style flexibility, and style effectiveness as a step forward in developing effective health care services leaders. Also, this study may

furnish valuable information to personnel who are responsible for improving hospital administrators' effectiveness in the following areas: (1) the development or revision of strategies for selecting hospital administrators, (2) the development or revision of training programs for hospital administrators, and (3) the development of in-service programs for hospital administrators.

The literature reviewed focused on those aspects of leadership that were most pertinent to this study. The areas explored fell into seven sections: background of Thai hospital and its administration, definitions of leadership, the history and evolution of leadership theories, review of Situational Leadership theories, Situational Leadership II theory, demographic variables in leadership studies, and research studies related to leadership styles of hospital administrators. The Situational Leadership II theory developed by Blanchard et al. (1985) provided the theoretical framework for this study.

The sample for this study consists of hospital administrators of government-operated general hospitals in Thailand. The basic source of the hospital administrators' leadership styles, primary leadership style, style flexibility, and style effectiveness was provided by the LBA II-Self and the LBA II-Other instruments by Blanchard et al. (1991 a,b). A demographic information questionnaire was developed to determine personal information for each hospital administrator surveyed in terms of age, educational

background, and years of experience in current position. The Statistical Analysis System (SAS) (Statistical Analysis System Incorporated, 1990) was used for analyzing the data. The data were analyzed using descriptive statistics--Chi-Square, Dependent-t, T-test, and Pearson's correlation coefficients. All tests employed the 0.05 level of significance.

Descriptive statistics were used to analyze data pertaining to hospital administrators' leadership styles, primary leadership style, style flexibility, and style effectiveness. The Chi-Square tests were used to determine whether there was a significant relationship between self-perceived and supervisors-perceived primary leadership styles of hospital administrators. The Chi-Square tests also used to determine the relationships between the hospital administrators' primary leadership style and each of the demographic variables. The dependent-t were used to test the differences between self-perceived and supervisors-perceived of leadership style flexibility and leadership style effectiveness. The  $t$  test were employed to analyze the difference between self-perceived and other-perceived hospital administrators' leadership style flexibility and leadership style effectiveness. The relationships between the hospital administrators' educational background, and leadership style flexibility and leadership style effectiveness were examined by using the  $t$  test. Pearson's correlation coefficients was used to examine the relationships between leadership style flexibility and

leadership style effectiveness, and the hospital administrators' age and years of experience in current position.

Frequency data relevant to the demographic information revealed that the majority of the administrators were over 55 years of age, possessed an educational background in the area of medicine without any extra education in the area of administration, and had 5 years or less experience in their current position.

Analysis of the data revealed the following:

1. The "supporting style" (S3) of high supportive and low directive was the primary leadership style of the majority of the hospital administrators as perceived by themselves and by their supervisors. That is, both groups viewed the hospital administrators as leaders who facilitate and support followers' efforts toward task accomplishment and share responsibility for decision-making with them.
2. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of flexibility in utilizing their leadership styles.
3. The administrators saw themselves as more flexible in utilizing different leadership styles than did their supervisors.

4. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of effectiveness in the use of their leadership styles.

5. There was a significant relationship between self-perceived primary leadership styles and supervisor-perceived primary leadership styles of Thai government hospital administrators.

6. There was a significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility of Thai government hospital administrators.

7. There was no significant difference between self-perceived leadership effectiveness and supervisor-perceived leadership effectiveness of Thai government hospital administrators.

8. The relationships between hospital administrators' primary leadership style and their age, educational background, and years of experience in current position was not statistically significant.

9. The relationships between hospital administrators' leadership style flexibility and age, educational background, and years of experience in current position was not statistically significant.

10. The relationships between hospital administrators' leadership style effectiveness and their age, educational background, and years of experience in current position was not statistically significant.

### Discussion

This study investigated the leadership styles, style flexibility, and style effectiveness of hospital administrators as self-perceived and as perceived by their supervisors. It also examined what relationships these hospital administrators had with selected demographic variables--age, educational background, and years of experience in current position.

The results on hospital administrators' leadership styles indicated that the predominant style of the hospital administrators was S3 or "supporting" style of high supportive and low directive behavior. According to Situational Leadership II theory, the "supporting" style is appropriate for the followers who have the ability and knowledge to do a particular task. The leader's role is to provide recognition and to actively listen and facilitate problem solving/decision making on the part of the follower.

The results on both hospital administrators' primary leadership style perceived by themselves and by others support Hersey and Blanchard's (1982) observation that the S3 style "tend[s] to be the most frequently identified . . . in the United States and other countries that have a high level of education and extensive industrial experience" (p. 251). Blanchard et al. (1987) explained supportive behavior with the following statements:

Supportive behavior is the extent to which a leader engages in two-way communication; listens, provides support and encouragement; facilitates interaction; and involves the followers in decision making. The three



operative words for supportive behavior are praise, listen, and facilitate" (p. 13).

In practice the hospital administrators might be effective in using the "supporting" style (S3) most of the time and with the majority of the personnel. But in some situations, especially when the followers lack competence but are enthusiastic about doing a particular task, such as happens with beginning personnel or personnel responsible for innovation programs, new projects, or new positions, the "supporting" style (S3) might be inappropriate based on the Situational Leadership II theory.

According to Situational Leadership II theory, a person's perception of how he/she behaves is interesting but it tells he/she only how he/she intend to act. Unless it matches the perceptions of others it is not very helpful (Blanchard et al., 1985). As the results, the supervisors' perception of primary leadership style, leadership style flexibility, and leadership style effectiveness were considered and used in analyzing the hypotheses as the hospital administrators' primary leadership style, leadership style flexibility, and leadership style effectiveness, respectively.

There was a significant relationship between self-perceived and supervisors-perceived primary leadership styles. There is strong agreement that the hospital administrators used the "supporting" style (S3) as their predominant leadership style. Both the hospital administrators and their

supervisors viewed the hospital administrators as supportive leaders. This supportive behavior is consistent with the general population and the norms of Thai culture.

According to Situational Leadership II theory, there is no one best leadership style and therefore, flexibility is important. The flexible leaders are the ones who could use all four leadership styles. However, without knowing when to use which leadership style with which people the leaders could get themselves into trouble (Blanchard et al., 1985). The leaders who use the wrong style with the wrong people at the wrong time are considered ineffectiveness (Blanchard et al., 1985). The results on hospital administrators' leadership style flexibility indicated that the hospital administrators possessed a moderate degree of this leadership style. There was significant difference between self-perceived leadership flexibility and supervisor-perceived leadership flexibility. That is, this study found that hospital administrator viewed themselves more flexible than the supervisors did. Perhaps the reason why the hospital administrators viewed themselves as more flexible than their supervisors did was because the administrators dealt with more people such as patients, nurses, technicians, and other staff. Additional study should be done to determine if the "supportive" style (S3) was overused and if the "directing" style (S1) is under-used.

The results on hospital administrators' leadership style effectiveness indicated that the hospital administrators possessed a moderate degree of this leadership styles and there was no significant different between self-perceived and supervisors-perceived of leadership style effectiveness. According to Situational Leadership II theory, leadership style effectiveness could be obtained when leaders show both a high degree in using leadership style flexibility and high degree in choosing the leadership style that is most appropriate for each situation (Zigarmi et al., 1991). This indicates that there was a need for these hospital administrators to learn how to utilize their leadership styles appropriately for different situations.

The reasons for having a moderate degree in both leadership style flexibility and leadership style effectiveness among the hospital administrators may be due to (1) a lack of time to supervise their subordinates since the hospital administrators were holding two positions at a time (being a medical doctor and an administrator) or (2) to culturally determined behavior--respect for others' ability and concern about others' feeling, which is the norm of Thai people, and is consistent with the "supporting" style (S3) of high supportive and low directive behavior.

This study revealed that there was no statistically significant relationship between leadership styles, primary leadership style, leadership style flexibility, and leadership style effectiveness and these selected

demographic variables: age, educational background, and years of experience in current position. According to the results of this study, there was insufficient evidence to prove that the hospital administrators with certain range of age, educational background, and years of experience in current position would be better leaders than the ones who were in different ranges.

These findings were indicators to support the assumption: (1) the hospital administrators' who were younger can be as effective as ones who were older, (2) the hospital administrators' who had no educational background in administration can be as effective as ones who had such education, and (3) the hospital administrators' who had shorter experience working in the current position can be as effective as ones who had longer experience. These findings might provide some information for individuals to develop or revise strategies in selecting or promoting hospital administrators.

This is the first study in which the LBA II instrument was used to study the hospital administrators of government-operated general hospitals in Thailand; therefore, more research is needed to confirm the results.

### Conclusions

Based on the results and discussion, the following conclusions are drawn:

1. The hospital administrators of government-operated general hospitals in Thailand used supportive behavior more often than directive behavior. They perceived themselves as supportive leaders as did their supervisors.
2. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of flexibility in utilizing their leadership styles. The administrators saw themselves as more flexible in utilizing different leadership styles than did their supervisors.
3. Both the hospital administrators and their supervisors perceived that the administrators possessed a moderate degree of effectiveness in the use of their leadership styles.
4. The factors of age, educational background, and years of experience in current position were unrelated to the leadership styles, leadership style flexibility, and leadership style effectiveness as perceived by both the hospital administrators and their supervisors.

## **Recommendations**

### **Recommendations for Practice**

Based on the results of this study, these recommendations for practice are made:

1. The following factors--age, educational background, and years of experience in current position--should not be included as important factors in the criteria for selecting or promoting hospital administrators. This recommendation is based on the study results that there was no significant relationship between any of those factors and the hospital administrators' leadership style effectiveness.

2. Training programs in leadership styles should be made available to help hospital administrators become sensitive to style flexibility and become more aware of the appropriateness of the styles they use. The most frequently used leadership style was "supporting" style (S3) and the least used style was "directing" style (S1) which might be caused by a lack of understanding of the style appropriate to the situation or cultural norm behavior. Thus it seems reasonable to include training in leadership behavior or leadership style in the curriculum for medical students in Thailand.

3. The Thai government should consider selecting people from other fields, especially the administrative field, to become hospital administrators for the government-operated hospitals. As the results of this study revealed

that the "directing" style (S1) of high directive and low supportive was the least used among hospital administrators. That is, these hospital administrators seldom used directive behavior such as giving order to their followers. This might be caused by the lack of time in supervising the subordinates since these hospital administrators had to do two jobs at one time--being medical doctors and administrators. The other solution to this problem is to let these hospital administrators take one job at a time--either being a hospital administrator or being a physician. However, the later solution (the hospital administrators were chosen to work only on administrative tasks) is not recommended since it will be a waste of medical resource which is insufficient in Thailand.

4. Hospital administrators should evaluate and diagnose their own leadership styles or ask others to evaluate and diagnose their leadership styles by using the LBA II-Self instrument and/or the LBS II-Other instrument to gain insight into their leadership styles, style flexibility, and style effectiveness and to improve the effectiveness of his/her own leadership behavior.

5. Situational Leadership II theory should be included in Thai medical school curriculum to help hospital administrators improve the effectiveness of their leadership behavior.

**Recommendations for Further Study**

Based on the results of this study, these recommendations for further study are made:

1. The subordinates' perception be used to study leaders' leadership styles as compared to leaders' self perception
2. Further study be done on the strength of each primary leadership styles
3. Qualitative research be conducted to reveal the possible factors that might relate to the leadership styles, style flexibility, and style effectiveness of hospital administrators in Thailand
4. Further experimental research be conducted to determine whether hospital administrators with training in Situational Leadership II theory are significantly different in utilizing their leadership styles, style flexibility, and style effectiveness from those without such training
5. The study be replicated to study leaders in other organizations in Thailand, such as leaders in other government-operated institutions, leaders in private hospitals, and managers in business organizations to determine whether similar results are obtained



## APPENDICES

## APPENDIX A--LBA II-SELF INSTRUMENTS

**PLEASE NOTE**

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in the author's university library.**

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## APPENDIX B--LBA II-OTHER INSTRUMENTS

## APPENDIX C--SCORING SHEET

## APPENDIX D--DEMOGRAPHIC INFORMATION QUESTIONNAIRE

# **DEMOGRAPHIC INFORMATION QUESTIONNAIRE**

## **Personal Information of Respondent**

**Please respond by checking (x) the appropriate item or filling in the space provided.**

1. Gender: ..... Male ..... Female
2. Age: ..... Years..... Month(s).
3. Official age ..... Years..... Month(s).
4. Years in current position ..... Years..... Month(s).
5. Highest degree earned ..... Bachelor's  
..... Master's  
..... Doctorate  
.... Other (Specify) .....
6. Major field of study in (a) Bachelor's is .....  
(b) Master's is.....  
(c) Doctorate is.....
7. Your hospital is in healthcare zone number .... (see the attached zone table).
8. Size of your hospital ..... beds
9. Number of physicians .....
10. Number of other employees .....
11. You usually read health/educational journals. .... Yes .... No  
If you check "yes" please write down list of the names of the journals you read.  
.....  
.....  
.....  
.....  
Time you spend in reading the journals mentioned ..... hours/weeks.
12. You attend training programs/workshops related to management or leadership area. .... Yes .... No  
If you check "yes", how often do you attend these programs/workshops.  
..... times/year

APPENDIX E--LIST OF PROVINCIAL CHIEF OFFICER (PCMO)  
IN 9 ZONES



## LIST OF PROVINCIAL CHIEF OFFICER (PCMO) IN 9 ZONES

ZONE 1

- |  |   |  |
|--|---|--|
| 1. NONTHABURI<br>-Pranangkrou<br>Nonthaburi              | 4. ANG THONG<br>-Ang Thong                          | 7. CHAINAT<br>-Chainat                   |
| 2. PATHUMTHANI<br>-Pathumthani                           | 5. LOPBURI<br>-Lopburi<br>-Banmee<br>Lopburi        | 8. SARABURI<br>-Praputtabath<br>Saraburi |
| 3. PRANAKORN<br>SRIAYUTTAYA<br>-Pranakorn<br>SriAyuttaya | 6. SING BURI<br>-Sing Buri<br>-In Buri Sing<br>Buri | 9. SAMUT PRAKARN<br>-Samut Prakarn       |

ZONE 2

- |                                      |  |
|--------------------------------------|--|
| 1. RAYONG<br>-Rayong                 | 4. PRACHIN BURI<br>-Chao Praya<br>Aphai Pubeth<br>Prachin Buri |
| 2. TRAT<br>-Trat                     | 5. NAKHON NAYOK<br>-Nakhon Nayok                               |
| 3. CHACHEOENG SAO<br>-Chacheoeng Sao |  |

ZONE 3

- |                        |                              |
|------------------------|------------------------------|
| 1. BURIRAM<br>-Buriram | 4. YASOTHON<br>-Yasothon     |
| 2. SURIN<br>-Surin     | 5. CHAIYAPHUM<br>-Chaiyaphum |
| 3. SISAKET<br>-Sisaket |                              |

ZONE 4

- |                                  |  |   |
|----------------------------------|--|---|
| 1. LOEI<br>-Loei                 | 5. KALASIN<br>-Kalasin                   | 8. MUKDAHAN<br>-Mukdahan                          |
| 2. NONG KHAI<br>-Nong Khai       | 6. SAKONNAKHON<br>-Sakonnakhon           | 9. MAE HONG SON<br>-Srisangwan<br>Mae<br>Hong Son |
| 3. MAHA SARAKAM<br>-Maha Sarakam | 7. NAKHON<br>PHANOM<br>-Nakhon<br>Phanom | 10. PHAYAO<br>-Phayao<br>-Chieng Kam<br>Prayao    |
| 4. ROI ET<br>-Roi Et             |  |   |

ZONE 5

- |                              |                            |                |
|------------------------------|----------------------------|----------------|
| 1. CHIANG MAI<br>-Chiang Mai | 3. UTTARADIT<br>-Uttaradit | 5. NAN<br>-Nan |
| 2. LAMPHUN<br>-Lamphun       | 4. PHRAE<br>-Phrae         |                |

ZONE 6

- |   |   |                              |
|---|---|------------------------------|
| 1. UTHAI THANI<br>-Uthai Thani          | 3. TAK<br>-Maesot Tak<br>-Somdej<br>Prachao<br>Taksin Tak | 5. PHICHIT<br>-Phichit       |
| 2. KAMPHAENG-<br>PHET<br>-Kamphaengphet | 4. SUKHOTHAI<br>-Sukhothai<br>-Srisangwan<br>Sukhothai    | 6. PHETCHABUN<br>-Phetchabun |

ZONE 7

- |                        |   |                          |
|------------------------|---|--------------------------|
| 1. KRABI<br>-Krabi     | 3. PHANG NGA<br>-Phang Nga<br>-Takuapa Phang<br>Nga | 5. CHUMPHON<br>-Chumphon |
| 2. RANGONG<br>-Rangong | 4. PHUKET<br>-Whachira<br>Phuket Phuket             |                          |

ZONE 8

- |                 |                 |                |
|-----------------|-----------------|----------------|
| 1. RATCHABURI   | 3. SUPHANBURI   | 6. PHETCHABURI |
| -Ban Phong      | -Chaophaya      | -Phachomklou   |
| Ratchaburi      | Yommaraj        | Phetchaburi    |
| -Photharam      | Supanburi       |                |
| Ratchaburi      |                 | 7. PRACHUAP-   |
| -Damnoen        | 4. SAMUT SAKHON | KIRIKHAN       |
| Saduak          | -Samut Sakhon   | -Prachuap      |
| Ratchaburi      |                 | Kirikhan       |
| 2. KANCHANABURI | 5. SAMUT-       |                |
| -Maharak        | SONGKHRAM       |                |
| Kanchanaburi    | -Samut-         |                |
| -Phaholpol      | Songkhram       |                |
| Phayuhaseina    |                 |                |
| kanchanaburi    |                 |                |

ZONE 9

- |             |                |                |
|-------------|----------------|----------------|
| 1. SONGKHLA | 4. PHATTHALUNG | 7. NARATHIWAT  |
| -Songkhla   | -Phatthalung   | -Narathiwat    |
| 2. SATUN    | 5. PATTANI     | -Sungai Ko-Lok |
| -Satun      | -Pattani       | Narathiwat     |
| 3. TRANG    | 6. YALA        |                |
| -Trang      | -Petong Yala   |                |

\* The names under "capitals" are Provincial Chief Medical Officer (PCMO) of each zone.

Under the PCMOs' names are general hospitals where operate under each Provincial Chief Medical Officer (PCMO).

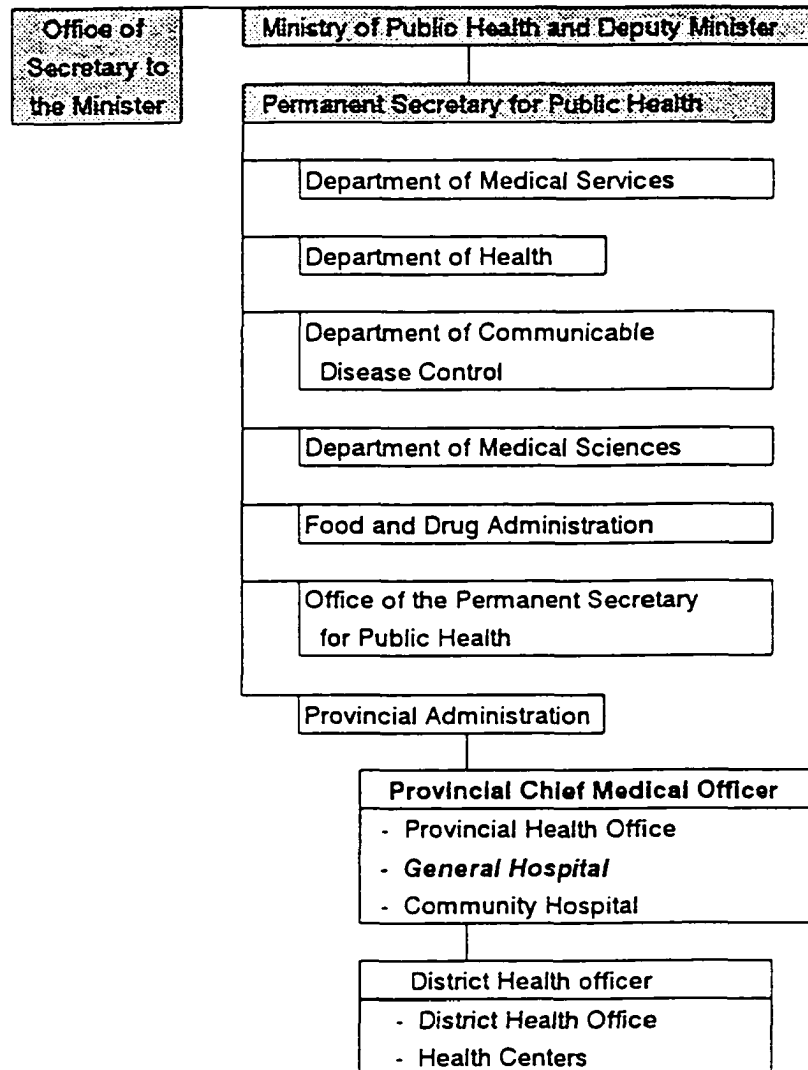
*Total 59 PCMOs in 9 zones*

Total 69 hospitals under 59 PCMOs in 9 zones

Source: Thai National Health Care Association. (1991). Patitin sataranasuk puttasakkaraj 2524. [Public health Year-book, 1991] (pp. 280-335). Bangkok: Sahaprachapanich Publishing.

## APPENDIX F--ORGANIZATIONAL CHART

## ORGANIZATION OF THE MINISTRY OF PUBLIC HEALTH



**Source:** Health Education Division and Health Planning Division. (1991).  
Health in Thailand 1991. Bangkok: Ministry of Public Health,  
Bangkok, Thailand Printing Office.

## APPENDIX G--PUBLIC HEALTH CARE FACILITIES, 1990

# PUBLIC HEALTH CARE FACILITIES, 1991

Administrative Division	Public Health Care Facilities	Number	Size (No. of beds)
Bangkok Metropolitan Administration	University Hospitals	5	1,000-2,300
	Special Institutions	22	150-500
	Major General's Hospital	32	300-1,000
4 Regions	University Hospitals	4	600-1,000
	Regional Hospitals	17	500-1,000
72 Provinces	General Hospitals	69	150-500
784 Districts	Community Hospitals	680	10-90
	Extended O.P.D.		-
7,003 Tambons	Health Centers	7,874	-
63,100 Villages	Drug Cooperatives	33,602	-

Source: Health Education Division and Health Planning Division. (1991). Health in Thailand 1991 (p. 36).  
Bangkok: Ministry of Public Health Bangkok Thailand Printing Office.

## APPENDIX H--LIST OF GENERAL HOSPITALS IN 9 ZONES

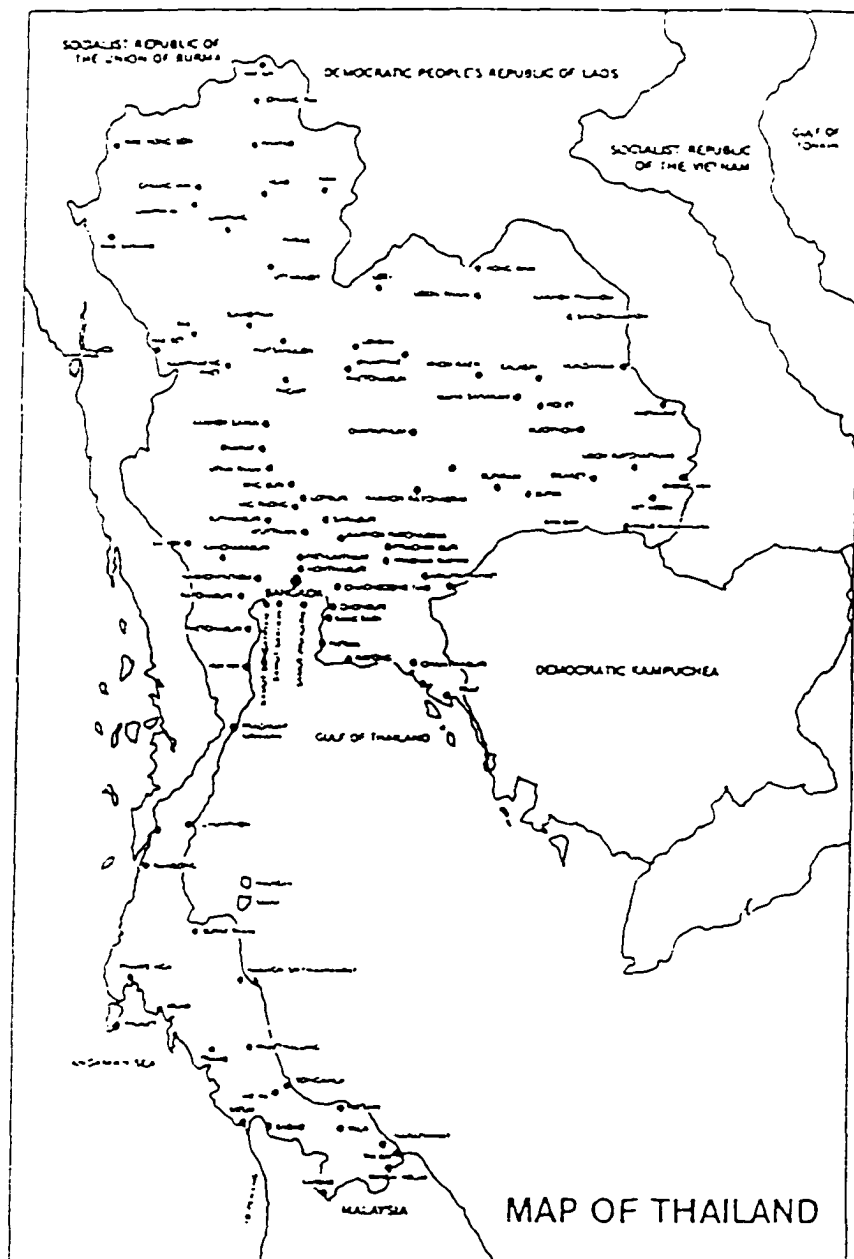


LIST OF GENERAL HOSPITALS IN 9 ZONES		
ZONE 1	ZONE 4	ZONE 7
1. Pranangklou Nonthaburi 2. Pathumthani 3. Pranakorn SriAyuttaya 4. Ang Thong 5. Lopburi 6. Banmee Lopburi 7. Sing Buri 8. In Buri Sing Buri 9. Chainat 10. Praputtabath Saraburi 11. Samut Prakarn	1. Loei 2. Nong Khai 3. Maha Sarakam 4. Roi Et 5. Kalasin 6. Sakonnakhon 7. Nakhon Phanom 8. Mukdahan	1. Ban Phong Ratchaburi 2. Photharam Ratchaburi 3. Damnoen Saduak Ratchaburi 4. Maharak Kanchanaburi 5. Phaholpol Phayuhaseina Kanchanaburi 6. Chaophaya Yommaraj Supanburi 7. Samut Sakhon 8. Samut Songkhram 9. Phachomklou Phetchaburi 10. Prachuap Kirikhan
ZONE 2	ZONE 5	ZONE 8
1. Rayong 2. Trat 3. Chacheoeng Sao 4. Chao Praya Aphai Pubeth Prachin Buri 5. Nakhon Nayok	1. Chiang Mai 2. Lamphun 3. Uttaradit 4. Phrae 5. Nan 6. Phayao 7. Chieng Kam Prayao 8. Srisangwan Mae Hong Son	1. Krabi 2. Rangong 3. Phang Nga 4. Takuapa Phang Nga 5. Whachira Phuket Phuket 6. Chumphon
ZONE 3	ZONE 6	ZONE 9
1. Buriram 2. Surin 3. Sisaket 4. Yasothon 5. Chaiyaphum	1. Uthai Thani 2. Kamphaeng phet 3. Maesot Tak 4. Somdej Prachao Taksin Tak 5. Sukhothai 6. Srisangwan Sukhothai 7. Phichit 8. Phetchabun	1. Songkhla 2. Satun 3. Trang 4. Phatthalung 5. Pattani 6. Petong Yala 7. Narathiwat 8. Sungai Ko-Lok Narathiwat

*Total 69 hospitals in 9 zones.*

Source: Thai National Health Care Association. (1991). Patitin sataranasuk puttassakkaraj 2534. [Public health Year-book, 1991] (pp. 40-41). Bangkok: Sahaprachapanich Publishing.

## APPENDIX I--MAP OF THAILAND



Source: Ministry of Public Health, Bangkok, Thailand. (1990). Thailand Health Profile 1990 (p. 2). Bangkok: Thai Government Printing Office.

APPENDIX J--LETTER GRANTING PERMISSION  
TO REPRODUCE MATERIALS

Blanchard Training  
and Development, Inc.



125 State Place  
Escondido CA 92029  
619 489-5005

October 21, 1992

(Andrews University)  
Pongsin Chuvattanakul  
500 Garland Ave  
Apt D-11  
Berrien Springs, MI 49103

Dear Pongsin:

I spoke with Dr. Zigarmi and we are happy to give you permission to duplicate the "Leader Behavior Analysis II" self, other and scoring instruments to be included in the appendix of your dissertation. Per our conversation, we understand that up to four (4) copies, and no more than four copies, of these will be reproduced in full, for each copy of your dissertation.

We will also grant you permission to re-print the Situational Leadership II (SLII) model, in the text of your dissertation. This model will be taken from the book entitled, "Leadership & The One Minute Manager." Again, we understand that no more than four (4) copies of our model will be re-produced.

Thank you and please let us know if there's anything else we can provide for you.

Sincerely,

A handwritten signature in cursive script, reading 'Leigh P. Strohn'.

Leigh P. Strohn  
Senior Sales Consultant

cc: Drea Zigarmi

APPENDIX K--LETTERS OF ENDORSEMENT  
(THAI AND ENGLISH VERSIONS)



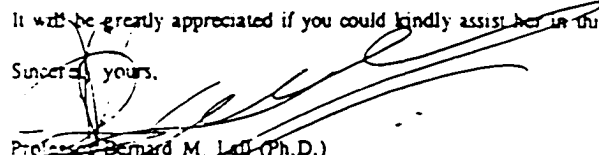
June 24, 1992

To Whom It May Concern

Mrs. Pongsin Chuwattanakul is presently working on her doctoral degree in Educational Administration and Supervision at Andrews University. She is also in the process of writing her dissertation. Her dissertation study pertains to hospital administrators' leadership styles of government operated hospitals in Thailand. I am indeed pleased that she has undertaken a study that is of paramount importance to her country and academia. Your input in this questionnaire is essential.

It will be greatly appreciated if you could kindly assist her in this survey.

Sincerely yours,

  
 Professor Bernard M. Lott (Ph.D.)  
 (Chairman of Pongsin Chuwattanakul's  
 Doctoral Committee)

Revised: September 1992



ด 0201/01/3959

กระทรวงสาธารณสุข

7 กรกฎาคม 2535

เรื่อง ขอความร่วมมือในการทำวิจัย

เรียน นายแพทย์สาธารณสุขจังหวัด ขุขันธ์ ข้าราชการ โรงพยาบาล

จังหวัดสงขลา แลกสอชงานข้อมูลทั่วไป และแบบประเมินพฤติกรรมผู้นำผู้บริหาร

ด้วย นางปองถิ่น ชูวัฒนกุล กำลังศึกษาในระดับปริญญาเอก สาขาการบริหารการศึกษา  
ณ มหาวิทยาลัยแอตแลนติก ประเทศสหรัฐอเมริกา กำลังทำเน้นการวิจัย เรื่อง "ลักษณะผู้นำของ-  
ผู้บริหารโรงพยาบาลรัฐบาลในประเทศไทย" ในการนี้ผู้วิจัยมีความประสงค์จะขอความร่วมมือจากผู้บริหาร  
โรงพยาบาลและผู้บริหารการสาธารณสุขในการตอบแบบสอบถาม เพื่อเป็นข้อมูลประกอบการวิจัย

ทั้งนี้ผู้วิจัยได้พิจารณาแล้วเห็นว่า การทำวิจัยดังกล่าวจะเป็นประโยชน์ต่อผู้บริหารการสาธารณสุข  
ในการบริหารงานและนำผลการการสาธารณสุข สดวกวให้การสนับสนุน

จึงเรียนมาเพื่อขอความอนุเคราะห์ และขอขอบคุณมา ณ โอกาสนี้

ขอแสดงความนับถือ

*One Sam*

(นายวุฒิ สดวกว)  
ปลัดกระทรวงสาธารณสุข



No. 0201/01/3959

Ministry of Public Health

July 7, 1992

SUBJECT: Request for Cooperation in Collecting Data for Research Study

TO: Government Hospital Directors/Supervisors

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Mrs. Pongsin Chuwattanakul is currently a doctoral student in the Area of Educational Administration and Supervision at Andrews University, U.S.A. She is conducting her dissertation research "Perceived Leadership Style, Style Flexibility, and Style Effectiveness of Government Hospital Administrators in Thailand." In this regard, the researcher would like to request your cooperation in responding to the questionnaires for the study.

Because the Ministry of Public Health considers this research study useful for the hospital directors in personnel development and administration, we encourage you to cooperate.

Thank you for your cooperation and your assistance in this matter.

Sincerely,

Under Secretary of State  
for Ministry of Public Health

APPENDIX L--COVER LETTER TO HOSPITAL ADMINISTRATORS  
AND THEIR SUPERVISORS IN SURVEY PACKAGE  
(THAI AND ENGLISH VERSIONS)

บ้านเลขที่ 7 ซอยสุราษฎร์  
ถนนพหลโยธิน สามเสนใน  
พญาไท กรุงเทพฯ 10400

6 กรกฎาคม 2535

เรื่อง ขอความอนุเคราะห์ในการคอมเมนต์สอบถามเพื่อการวิจัย

เรียน นายแพทย์ผู้อำนวยการโรงพยาบาล

สิ่งที่ส่งมาด้วย แบบสอบถามข้อมูลทั่วไป และแบบประเมินพฤติกรรมผู้นำสำหรับผู้บริหาร

ด้วยกิจกำลังศึกษาปริญญาเอก สาขาบริหารการศึกษา ณ มหาวิทยาลัยแอตแลนติก ประเทศสหรัฐอเมริกา มีความประสงค์จะขอเก็บรวบรวมข้อมูล เพื่อประกอบการทำวิทยานิพนธ์ เรื่อง "ลักษณะภาวะผู้นำของผู้บริหารโรงพยาบาลรัฐบาลในประเทศไทย"

งานวิจัยครั้งนี้ เป็นการสำรวจความคิดเห็นของผู้บริหารโรงพยาบาล ซึ่งเป็นกลุ่มตัวอย่างจำนวน 128 คน ผลของการวิจัยจะบอกให้ทราบถึง รูปแบบภาวะผู้นำ และประสิทธิภาพของรูปแบบภาวะผู้นำของผู้บริหาร ซึ่งมีส่วนเกี่ยวข้องกับความสำเร็จของการจัดการสาธารณสุข ท่านเป็นผู้หนึ่งที่มีส่วนในการให้ข้อมูล สำหรับการศึกษาวิจัยนี้ จึงจึงใคร่ขอความกรุณาจากท่าน โปรดกรุณาสอบถามที่แนบมาพร้อมกัน จดหมายนี้ ด้วยตัวของท่านเอง แล้วส่งคืนมายังผู้วิจัยภายในวันที่ 30 กรกฎาคม 2535 โดยทางไปรษณีย์ ความສອນທີ່ອຸ່ງຢູ່ປະກາດຢູ່ໃນແບບສອນຖ້າ ຈະສອນຜະຈົນ

ข้อมูลส่วนตัว ที่ได้รับจากท่านทุกอย่างผู้วิจัยจะถือเป็นความลับ และใช้เพื่อการวิจัยเพียงอย่างเดียว สำหรับหมายเลขที่มุมล่างของแบบสอบถาม เป็นหมายเลขที่ใช้เพื่อการตรวจสอบ และการติดตามผลการตอบกลับของข้อมูลเท่านั้น

จึงเรียนมาเพื่อขอความอนุเคราะห์จากท่าน โปรดโปรดสละเวลาประมาณ 15 นาที ในการตอบแบบสอบถาม และส่งกลับคืนไปยังผู้วิจัยด้วย ขอขอบคุณเป็นอย่างสูงมา ณ โอกาสนี้

ขอแสดงความนับถือ





# ANDREWS UNIVERSITY

500 Garland Apt. D-11  
Bernier Springs  
MI 49193 USA

June 30, 1992

SUBJECT: Request for Cooperation in Completing Questionnaire  
TO: Government Hospital Directors / Supervisors

I am a doctoral student in the School of Education under the Educational Administration and Supervision Department at Andrews University, U.S.A. Presently, I am conducting a research for my doctoral dissertation entitled "Leadership Styles, Style Flexibility, and Style Effectiveness of Government Hospital Directors in Thailand." This study surveys the self perception of 69 government hospital directors and 59 government hospital directors' supervisors. The results of the research will reveal the leadership styles, style flexibility, and style effectiveness of the government hospital directors. As one of leaders in our country's health care services, you are selected and requested to participate in the study. Your contribution in this study will be of paramount importance to our country.

I would like to ask you to complete the questionnaire and the LBA II-Self (for the hospital directors) or the LBA II-Other (for the supervisors) and return them to me by July 30, 1992. The questionnaire is simple and concise and should take only about ten minutes of your precious time to complete. Your input will be treated with the strictest confidentiality. You need not put in your name.

Enclosed herewith are:

1. a letter of introduction from my advisor
2. a set of questionnaires:
  1. LBA II-Self (for the hospital directors) or
  2. LBA II-Other (for the supervisors)
  3. a demographic questionnaire
3. a stamped self-addressed envelope (address to the Ministry of Public Health where is a collecting-center for all the incoming data for this study)

Thank you very much for your kind assistance. I look forward to receiving your completed questionnaire soon.

Sincerely,

Pongsun Chuwanakul

Bernier Springs, Michigan, 49193-0001

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## BIBLIOGRAPHY

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VITA

## VITA

NAME: PONGSIN CHUWATTANAKUL

DATE OF BIRTH: MAY 2, 1959

PLACE OF BIRTH: Bangkok, Thailand

### EDUCATION:

- |      |   |
|------|---|
| 1993 | Doctor of Philosophy<br>Educational Administration and Supervision<br>Andrews University, Berrien Springs, Michigan, U.S.A.   |
| 1991 | Educational Specialist<br>Educational Administration and Supervision<br>Andrews University, Berrien Springs, Michigan, U.S.A. |
| 1991 | Master of Arts - Educational Administration<br>Andrews University, Berrien Springs, Michigan, U.S.A.                          |
| 1990 | Master of Science - Administration<br>Andrews University, Berrien Springs, Michigan, U.S.A.                                   |
| 1980 | Bachelor of Law<br>Chulalongkorn University, Bangkok, Thailand  |

### PROFESSIONAL EXPERIENCE:

- |           |   |
|-----------|---|
| 1990-1993 | Graduate Assistant<br>Andrews University, Berrien Springs, Michigan, U.S.A. |
| 1980-1987 | Head, Public Relations Department<br>Samitivej Hospital, Bangkok, Thailand  |